Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit A

SMYSER KAPLAN & VESELKA, L.L.P.

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February 25, 2009

Mr. Phillip A. Pfeifer
Phillip A. Pfeifer, P.C.
5216 Jackson Street
Houston, TX 77004

Via Certified Mail-RRR

Re: CA No. 07-03973; *Wendy Guzman vs. Memorial Hermann Hospital System; In the United States District Court, Southern District of Texas, Houston Division*

Dear Phil:

Enclosed are additional Emergency Center policies (bates numbered MHSE-TG-0287 through 0297). Also enclosed is a redacted list of patients for whom Dr. Haynes ordered CBC with Differential from February 12, 2005 through February 12, 2006 (bates numbered MHSE-TG-0298 through 0300).

This shall serve as Memorial Hermann Hospital System d/b/a Memorial Hermann Southeast Hospital's supplemental response to all discovery requests.

Sincerely,

Chris Bryan

CAB/tm
Encls.

cc: Mr. Charles Brennig, III
The Henke Law Firm, LLP
3200 Southwest Freeway, 34th Floor
Houston, Texas 77027

Memorial Hermann Hospital System: EMERGENCY CENTER TRIAGE GUIDELINES

(Original document 6-1-99, REVISED 4-11-00, revised 10-17-00, revised 4/17/01, 5-30-02)

These guidelines have been developed to assist in expediting patient flow. These orders are substantiated based on the patient's chief complaint and the documented nursing assessment. They are meant to assist the staff in ordering appropriate studies which expedites evaluation by the physician or physician extender. The patient is to be brought directly to a room if one is available. They are not intended to delay physician evaluation. Triage guidelines may be initiated by the appropriate provider in the triage area or by the nurse assigned to the patient room if the patient is brought directly back. These protocols should not in any way delay the physician or physician extender evaluation, not meant in any way to be interpreted as a standard of care. They have been reviewed and approved by the site medical director and administrative director.

Protocols are designed based on Chief complaint. IV rates should be obtained from the physician. Large bore IV is considered 16 or 18 gauge. It is accepted that IV starts, blood draws, performing EKG's, placing a patient on an EKG monitor, performing a bedside glucose determination, and oxygen administration are within the scope of practice of the ED tech and may be initiated by these providers. These providers, however, may only accomplish this after appropriate in servicing and documentation of skill/competency.

In event that a patient leaves prior to evaluation by the practitioner, the nursing staff must present all staged labs, EKGs, and/or X-rays to the attending MD physician. These will then be reviewed by the physician, if required, the patient will contacted and advised to return to the Emergency Center.

ABDOMINAL PAIN

FEMALE
NPO
- CBC,
- HCG if childbearing age/HCG Quantitative if known pregnancy
- UA clean catch - Female cath specimen if vag. bleeding ↑ vag. Discharge or obese (Foley preferable if elderly, incontinent)
- Save extra tubes (draw 4 tubes)

Consult MD/MLP for pelvic exam as indicated
Saline lock (18 G) for severe pain or unstable V/S
Old chart

MALE
NPO
- CBC
- Collect and hold urine
- Save extra tubes (draw 4 tubes)

Saline lock (18 gauge) for severe pain
Old chart

ALTERED MENTAL STATUS (NONTRAUMATIC)

Notify MD on arrival
O2 by nasal cannula at 2L/min
Cardiac, BP and pulse oximetry monitors
Saline lock (18g or larger)
Stat bedside glucose
- CBC
- BMP
- UA (Foley as appropriate)
- HCG if childbearing age/HCG Quantitative if known pregnancy
- Save and hold blood tubes

Old chart

AMBULANCE PATIENTS WITH SPINAL IMMOBILIZATION

TRIAGE: Immediately notify the MD and/or MLP for any patient with complaint or finding suspicious of a spinal cord injury (numbness or weakness)
Notify the MD/MLP pt is awaiting room (may be assessed in hallway)
MD/MLP will assess patients with neck pain for X-table lateral, C-spine order
*Ambulatory patients presenting with significant mechanism of injury and neck pain should be appropriately immobilized in triage

ANAPHYLACTIC REACTIONS

Notify MD on arrival
O2 by nasal cannula at 2L/min if dyspnea/shock
Cardiac, BP, and pulse oximetry monitors
Saline lock
IV NS (large bore) if pulse ≥120 and/ or BP ≤ 90. (ask MD for rate)
Request MD medication order as appropriate
Old chart

CVA/STROKE

Notify MD on arrival
Frequent Neuro reevaluation and record
Cardiac, BP, and pulse oximetry monitors
O2 by nasal cannula at 2L/min
Alert CT of potential CT scan
Saline lock
- CBC
- BMP
- PT/PTT
- Save extra tubes

EKG
Old chart

CHEST PAIN (SUGGESTIVE OF CARDIAC DISEASE > 35 YEARS)

Obtain EKG in triage if no bed immediately available and show to MD
O2 by nasal cannula at 2L/min
Cardiac, BP and pulse oximetry monitors
Saline lock (consider twin lumen catheter)
- CBC
- BMP
- CK
- CKMB
- Troponin T

Medications
- ASA - 325 mg po if not allergic, on anticoagulant, and not received prior to arrival
- NTG - 1/150 gr. SL q 5 min x 3 for c/p if patient previously on nitrates and blood pressure > or = 100mm. **Do not give NTG if received prior to arrival or if patient has taken Viagra within 24 hours (without consulting MD first)

Old Chart

DIABETIC KETOACIDOSIS (KNOWN DIABETIC WITH N/V, KUSSMAUL RESP, AND/OR ODOR ACETONE ON Breath)

Notify MD on arrival
Cardiac and BP monitors
IV normal saline (large bore) Request rate from MD
Stat bedside glucose
- CBC
- BMP
- Serum acetone
- UA voided

Old chart

DIABETES WITH HYPOGLYCEMIA

Adult patients presenting with altered mental status and potential hypoglycemia:
Obtain STAT bedside fingerstick
Saline lock
- BMP
- Save and hold 4 blood tubes

Administer D50 1 amp for finger stick of < 50
Notify MD immediately

DYSPNEA (PEDIATRICS)

Notify MD on arrival if patient is distressed with rapid or labored respirations, use of accessory muscles or O2 sat ≤ 92% on Room air on arrival
Follow adult dyspnea protocol with the following medications:
1. If O2 sat ≤ 92% give O2 by nasal cannula at 3L/min or mask (10L) to younger children
2. If wheezing present - Albuterol 0.5 cc Neb Tx Zopenex may be substituted
3. Peak flow before/after every treatment
4. Delete BP monitoring if arrival BP monitoring normal
5. Delete cardiac monitoring if pulse ≤ 150 (child < 6 yr. old)

DYSPNEA (ADULT)

Notify MD if distressed or O2 sat ≤ 92%
O2 by nasal cannula at 2L/min
Cardiac, BP and pulse oximetry monitors
Saline lock if pt is distressed or arrival O2 sat ≤ 92%
Lab - Aminophylline level if pt. taking this, hold extra tubes
If wheezing present - Neb Tx - Albuterol 0.5cc (Atrovent 1 unit dose if no history of glaucoma)
Peak flow before/after every Neb Tx

EXTREMITY FRACTURES (EXTREMITIES ONLY)

Notify the MD on arrival for suspected long bone fractures any ANY open fractures
Immobilize injury as appropriate
Elevate the injured area
Apply an insulated cold pack to the area
Perform neurovascular exam
Consider pregnancy potential before x-raying and offer pregnancy testing in nonemergent/equivocal cases (or consider shielding for x-rays)
Order 1 but not more than 2 sets of the following selections: shoulder, humerus, elbow, forearm, wrist, hand, finger(s), femur, knee, tib/fib, ankle, foot, or toe(s). If > 2 sets are required, MD/MLP consultation regarding ordering should be done
Notify the MD for any abnormalities: cyanosis, pallor, weak or absent pulse, gross deformity, absence of sensation, absence of movement, suspicion of open fracture, inability to weight bear if pain is in hip or thigh

EYE INJURIES

Notify MD immediately for:
- acute chemical burns
- hyphema
- Suspected globe rupture (leak of humor)
- Penetrating injury

Visual acuity and record
Slit lamp and Eye tray to room

MD = Emergency Room Physician
MLP = Mid-Level Practitioner (NP, PA, etc...)
08/13/02

Prepare to irrigate chemical injuries (on the MD's order) with lactated ringers
Administer DT 0.5 cc IM as ordered

FEVER: PEDIATRIC (< 3 MONTHS)
If temp ≥ 100.6 F rectally, notify MD immediately to consider septic work-up
4 WEEKS:
Notify MD immediately
Saline Lock
- Blood Culture x 1
- CBC
- BMP
- UA (cath)

Chest x-ray
Prepare for potential LP and IV infusion

FEVER: PEDIATRIC (3 MONTHS TO 18 YRS)
1. Tylenol 15mg/kg Temp ≥ 101F. Compensate for parental underdosing prior to child's arrival. Avoid po route for patients presenting with a chief complaint of abd. Pain Exceptions: Allergy or age less than 60 days - notify MD
2. Pediatric Motrin 10 mg/kg Temp ≥102.5F Exceptions: allergy to ibuprofen, NSAID, ASA; age less than 6 months; prior history of GI bleed, gastritis, ulcer or asthma; suspected chicken pox (varicella) or influenza; Tylenol has not been given by protocol; presentation of abdominal pain as a chief complaint

FEVER: ADULT - Fever > or = 101F
Tylenol 650-1000mg po unless allergic
OR
Motrin 400-800 mg po unless allergic including NSAID/ASA

KIDNEY STONE (SUSPECTED)
Notify MD for severe pain and request medication
Strain all urine
Saline lock
- CBC
- BMP
- UA clean catch - Female cath specimen if vag. bleeding ↑ vag. discharge or obese (Foley preferable if elderly, incontinent)

Old chart

HEAD INJURY
Notify MD on arrival
Follow major trauma protocol as indicated including care/evaluating of C-spine
Cardiac, BP, and pulse oximetry monitors
Position head higher than feet, immobilize C-spine
Glascow coma scale (document HOURLY)
Old chart

GI BLEEDING
Notify MD for active bleeding or unstable vital signs
O2 by nasal cannula at 2L/min
Position head lower than feet if shock is present (BP ≤ 90/60)
Cardiac and BP monitors
IV NS (large bore) and request a rate from the MD
- CBC
- BMP
- PT/PTT
- Type and screen
- Save and hold 4 extra tubes

Orthostatic VS if tolerated and BP ≥ 90 mm hg
Old chart

HTN WITH S/S (> 180/110, HEADACHE, BLURRED VISION, DIZZINESS, ETC.)
Notify MD on arrival
O2 by nasal cannula at 2L/min
Cardiac and BP monitors
Saline lock
Take and record BP on both arms
- CBC
- BMP
- HCG - if childbearing age
- Save and hold 4 extra tubes

EKG if age ≥ 35 yr.
Old chart

LACERATION PREP
Unless directed otherwise by MD, perform the following procedure utilizing aseptic technique:
1. In triage, examine the wound and then cover with sterile gauze, which has been slightly moistened with normal saline. Do not soak the wound in saline, water, or betadine
2. After MD and/or MLP evaluation, set up/open suture tray, place suture material as ordered by MD/MLP
3. Apply sterile moistened saline gauze if there will be a delay in anesthetic administration
4. Wound irrigation may be performed by the MD and/or MLP or as directed by the MD/MLP and will typically be of the high pressure type employing a syringe and needle or cath. (20 cc syriage and 18g catheter), and using an appropriate volume of NS
5. Administer DT 0.5cc IM to adults as ordered by MD/MLP

URINARY TRACT INFECTION (SUSPECTED)
- UA - males clean catch / females clean catch - cath specimen if vag. bleeding ↑ vag. discharge or obese (Foley preferable if elderly, incontinent)
- Hold urine for C&S (request from MD)
- HCG if childbearing age/HCG Quantitative if known pregnancy

Old chart

SEIZURES
Notify MD on arrival
Guardrails up
Document neuro assessment
Cardiac, BP, and pulse oximetry monitors
Apply O2 as needed to maintain saturation > 90%
Saline lock
Lab- draw and hold tubes, order therapeutic drug levels if appropriate
** New onset seizures order CBC, BMP (HCG for women of child bearing age)
Old Chart

SHOCK (NONTRAUMATIC)
Notify MD on arrival
Administer O2 to maintain sat. > 90% via facemask or cannula
Cardiac, BP, and pulse oximetry monitors
IV NS (large bore) and request a rate from the MD
Modified Trendelenberg position
- Blood culture if febrile or hypothermic
- CBC
- BMP
- UA (Cath)
- PT/PTT
- HCG if childbearing age

Portable CXR
EKG
Old chart

SICKLE CELL PAIN CRISIS
Apply O2 per nasal cannula at 2L
Normal Saline IV line
- CBC
- BMP
- Retic count
- UA for patient with back/flank pain Female cath specimen if vag. bleeding ↑ vag. discharge or obese (Foley preferable if elderly, incontinent)

Add CXR PA/lateral for cough/fever, dyspnea
Notify MD immediately for pain medications and fluid bolus/ therapy

VAGINAL BLEEDING
NPO
Orthostatic V/S,
**FHT's if known pregnancy
IV access (larger bore), saline lock if stable. If unstable, request IV fluids / rate from MD
Notify MD if unstable, severe bleeding, severe pain, or passage of tissue
Consult MD and/or MLP for coordination of pelvic exam
- CBC
- HCG if childbearing age/HCG Quantitative if known pregnancy

Old chart

VOMITING/DIARRHEA: PEDIATRIC (2 MONTHS TO 18YR)
Notify MD if:
- child appears toxic
- Dehydration,
- Vital signs are abnormal

Use protocol for pedi fever
- Saline lock, CBC and BMP if child appears significantly dehydrated
- UA voided (bag or clean void) if 3 or more episodes of vomiting or if UTI symptoms present and not likely to be contaminated by stools, Cath UA requires order from MD

PSYCHIATRIC PATIENT (SUICIDAL/HOMICIDAL)
If patient is an active threat to self/others, triage to bed (for patient protection consider security to bedside or psych tech to bedside) Restraint per policy.
Notify MD for expedited eval and medical clearance
Page Psych response for consultation/eval (may be done at triage to expedite eval)
Consider Tylenol and ASA level for any suspicion of overdose
- CBC
- BMP
- ETOH
- UDS
- HCG if childbearing age & no hysterectomy

TRAUMA
Notify MD on arrival
Notify trauma team if patient meets trauma activation criteria
O2 by nasal cannula at 2L/min or high flow mask as appropriate
Cardiac, BP, and pulse oximetry monitors
IV NS (large bore) x 2 and request rate
Modified Trendelenberg position if BP < or = 90/60
Stat x-table portable C-spine x-ray for head injury, neck pain, or suspected neck injury (immobilize c-spine)
Stat portable CXR for injury to chest, back, abd, or pelvis

MD = Emergency Room Physician
MLP = Mid-Level Practitioner (NP, PA, etc...)
08/13/02

Clean obvious wounds and apply sterile saline dressing

- CBC
- BMP
- HCG if childbearing age
- UA (request collection method from MD or if decreased level of consciousness or shock present)
- For abdominal pain/ injury - consider PT/PTT, type and screen, hold extra tubes,

EKG for chest injury or shock
Old Chart

TRAUMA: PREGNANCY > 20 WEEKS
Notify MD immediately
See above guideline
Record vital signs and FHTs

MD = Emergency Room Physician
MLP = Mid-Level Practitioner (NP, PA, etc...)
08/13/02

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit B

SMYSER KAPLAN & VESELKA, L.L.P.

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February 25, 2009

Mr. Phillip A. Pfeifer
Phillip A. Pfeifer, P.C.
5216 Jackson Street
Houston, TX 77004

Via Certified Mail-RRR

Re: CA No. 07-03973; *Wendy Guzman vs. Memorial Hermann Hospital System; In the United States District Court, Southern District of Texas, Houston Division*

Dear Phil:

Enclosed are additional Emergency Center policies (bates numbered MHSE-TG-0287 through 0297). Also enclosed is a redacted list of patients for whom Dr. Haynes ordered CBC with Differential from February 12, 2005 through February 12, 2006 (bates numbered MHSE-TG-0298 through 0300).

This shall serve as Memorial Hermann Hospital System d/b/a Memorial Hermann Southeast Hospital's supplemental response to all discovery requests.

Sincerely,

Chris Bryan

CAB/tm
Encls.

cc: Mr. Charles Brennig, III
The Henke Law Firm, LLP
3200 Southwest Freeway, 34th Floor
Houston, Texas 77027

MHHCS
CORPORATE POLICY AND PROCEDURE MANUAL

POLICY TITLE: Assessment/Reassessment

CATEGORY: Emergency Center
INDEX NUMBER: EMC-00006
ORIGINAL DATE: 6/30/2005
LAST REVIEW DATE: 7/1/2005
SUPERCEDES:

---

1. PURPOSE:

1.1 To determine the severity of illness or injury for all patients who present to the Emergency Department for treatment. To perform a systematic and comprehensive evaluation of those illnesses or injuries and initiate appropriate interventions

2. STATEMENT:

2.1 Assessments are divided into primary and secondary surveys. Assessments shall be initial and ongoing.

3. PROCEDURE:

3.1 Primary Survey:

3.1.1 Involves a brief, rapid assessment to identify actual or potential, life threatening illness or injury:
- 3.1.1.1 Airway
- 3.1.1.2 Breathing
- 3.1.1.3 Circulation
- 3.1.1.4 Disability
  - 3.1.1.4.1 GCS (Glascow Coma Score)

3.2 Secondary Survey:

3.2.1 Involves a more focused & detailed evaluation of the patient to identify other, less severe, non-life-threatening, illness or injury. After the life-threatening issues have been addressed, the following should be obtained:

3.2.1.1 **Vital signs**: a complete set of vital signs, when clinically indicated, including pulse oximetry and pain scale, should be obtained.

3.2.1.2 **Head to toe assessment of body systems**, when clinically indicated. The assessment may be focused on only the area of complaint, or the entire body.

3.2.1.3 **Cardiac rhythm**: When clinically indicated (ie: chest pain, arrhythmia), an EKG should be obtained & monitor strip mounted on the nurses notes as a baseline and whenever significant changes in rate, rhythm or ectopy occur.

3.2.1.4 **Glascow coma scale**: should be obtained on all patients when clinically indicated (ie: head trauma, altered mental status). All trauma patients require an admission GCS.

3.2.1.5 **Last menstrual period**: should be obtained on all female patients of child bearing age, when clinically indicated (ie: abdominal pain, vaginal bleeding).

3.2.1.6 **Immunization history**: (specifically last tetanus) should be obtained on all patients, when clinically indicated (ie: laceration, all trauma patients).

3.2.1.7 **Weight**: should be obtained on all pediatric patients and any patient requiring medications with weight based dosing (ie: rabies immunization, heparin). Weight should be actual (by scale) , not estimated/stated weight.

3.2.1.8 **Head circumference**: should be obtained on children < 12 months when clinically indicated (ie: hydrocephalus, failure to thrive).

3.2.1.9 **Visual acuity**: should be obtained when clinically indicated.

3.2.1.10 **Past medical & surgical history**: any significant medical or surgical history should be ascertained & documented in the chart.

3.2.1.11 **Current medications**: A complete list of the patients' medications, including over the counter & herbal/natural remedies should be documented in the chart.

3.2.1.12 **Allergies**: A complete list of the patients' allergies should be listed in the chart.

3.3 Reassessment:

3.3.1 The frequency of reassessment is based on the patient's acuity, condition, history & complaint, or as directed by the Physician; minimally every four (4) hours.

3.3.2 Timing of reassessments should reflect the patients' status at any given moment they are in the Emergency Center.

3.3.3 An additional set of vital signs, including temperature and GCS, when clinically indicated, should be obtained within one hour of patient's discharge.

APPROVED: Thomas J. Flanagan, RN, BSN, MA, LP, CMTE
Assistant Vice-President
Corporate Emergency Services

APPROVED: John Zerwas, MD
Sr. Vice President & Chief Medical Officer
Memorial Hermann Healthcare System

DATE: June, 2005

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit C

SMYSER KAPLAN & VESELKA, L.L.P.

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February 25, 2009

Mr. Phillip A. Pfeifer
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5216 Jackson Street
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Via Certified Mail-RRR

Re: CA No. 07-03973; *Wendy Guzman vs. Memorial Hermann Hospital System; In the United States District Court, Southern District of Texas, Houston Division*

Dear Phil:

Enclosed are additional Emergency Center policies (bates numbered MHSE-TG-0287 through 0297). Also enclosed is a redacted list of patients for whom Dr. Haynes ordered CBC with Differential from February 12, 2005 through February 12, 2006 (bates numbered MHSE-TG-0298 through 0300).

This shall serve as Memorial Hermann Hospital System d/b/a Memorial Hermann Southeast Hospital's supplemental response to all discovery requests.

Sincerely,

Chris Bryan

CAB/tm
Encls.

cc: Mr. Charles Brennig, III
The Henke Law Firm, LLP
3200 Southwest Freeway, 34th Floor
Houston, Texas 77027

MHHCS
CORPORATE POLICY AND PROCEDURE MANUAL

POLICY TITLE: Documentation

CATEGORY: Emergency Center
INDEX NUMBER: EMC-00007
ORIGINAL DATE: 6/30/2005
LAST REVIEW DATE: 7/1/2005
SUPERCEDES:

POLICY PURPOSE:

1.1 To provide guidelines for documentation expectation for every Emergency Center patient.

2. POLICY STATEMENT:

2.1 Each patient will be placed into the Med Host tracking and charting system upon arrival to triage and each patient will have an Emergency Center Nursing Record completed.

3. PROCEDURE:

3.1 The Emergency Center Nursing Record will be initiated on the patient on arrival, with all required identification and demographic data.

3.2 A Pediatric Emergency Nursing Record will be initiated on all patients less than 14 years old.

3.3 Trauma Nursing Record will be initiated on all patients who have traumatic mechanism of injury, vital signs or who meet physiological criteria in all facilities that are Designated Trauma Centers.

3.4 3.4.1 The Registered Nurse will document the time of the patient presentation and initial triage assessment time, the patient's primary complaint, triage acuity level, allergies, current medications, recent tetanus vaccine (if appropriate), initial vital signs, significant past medical history, room disposition when placed into a EC room and actual weights on children less than thirteen years old.

3.4.2 Reassessments and vital signs will be documented as directed in the assessment/reassessment policy.

3.5 All orders must be initialed and timed when completed.

APPROVED: Thomas J. Flanagan, RN, BSN, MA, LP, CMTE
Assistant Vice-President
Corporate Emergency Services

APPROVED: John Zerwas, MD
Sr. Vice President & Chief Medical Officer
Memorial Hermann Healthcare System

DATE: June, 2005

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit D

MHHS
MEMORIAL HERMANN SOUTHEAST HOSPITAL
POLICY AND PROCEDURE MANUAL

POLICY TITLE: AFTERCARE INSTRUCTIONS AND FOLLOW-UP

CATEGORY:	Emergency Services
INDEX NUMBER:	EMS-00015
ORIGINAL DATE:	4/1/1997
LAST REVIEW DATE:	6/22/2005
SUPERCEDES:	07/25/2003

POLICY PURPOSE:

1. All patients who are treated in the Emergency Department will receive follow-up care instructions.

POLICY STATEMENT:

1. The aftercare instruction will be given verbally by the nurse or physician to the patient, appropriate caregiver or significant other. The aftercare instruction page should be signed by the nurse/physician and patient. Original remains with the chart and patients will be given written copies of the aftercare instruction page.
2. When the Emergency Department physician determines a need for change in follow-up of care and treatment in regards to final diagnostic results (to include culture and x-ray reports) after the patient has been discharged, they are to:

    2.1 Initiate the Emergency Department *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form.*
    2.2 Document request and when appropriate, write a prescription.
    2.3 The nurse will document the outcome.

3. The Emergency Department Follow-Up/Patient Consultation for Lab and X-Ray Reports Form is to remain with the chart. A copy of any correspondence should be put in the patient's record.
4. It is the responsibility of the charge nurse or designee to:

    4.1 Promptly respond to follow-up reports
    4.2 Document any recommended changes in treatment plan on the *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form.*
    4.3 If it is a diagnostic follow-up change for any further recommended tests or medications that are needed after the patient is discharged from the Emergency Department:

4.3.1 Patient will be contacted and notified by phone.
4.3.2 A certified letter will be sent out within 48 hours of notice of change in treatment plan if unable to reach by phone.

5. Culture/Sensitivity Follow-up Protocol

5.1 All culture and sensitivity reports are reviewed by the physician or Mid-Level Providers (MLP) as they are returned from the laboratory, to ascertain that the appropriate antibiotic therapy has been administered in accordance with the sensitivity patterns.
5.2 If the report was evaluated by the Emergency Department physician and found that a more appropriate antibiotic should have been ordered, it will be brought to the attention of the current physician or MLP on duty for a recommended change in treatment plan and a prescription will be written as appropriate and follow-up procedure followed.

6. Diagnostic Imaging Follow-Up Protocol

6.1 Next day confirmed reading from radiologist with recommended follow-up will be brought to the Emergency Department.
6.2 Nurse/unit secretary will document:

6.2.1 Document the confirmed change on the *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form.*
6.2.2 Retrieve the chart
6.2.3 Give confirmed reading, chart, and Emergency Department *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form* to the Emergency Department physician or MLP on duty.

6.3 Physician or MLP on duty fills out the Emergency Department *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form* then gives it and the prescription to the charge nurse/Fast Track nurse.
6.4 Nurse/unit secretary will:

6.4.1 Log the final recommendation on the *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form.*
6.4.2 Call the patient to have the test done.
6.4.3 If unable to reach by phone, a certified letter will be sent within 24 hours.
6.4.4 Follow the protocol for documenting on Emergency Department *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form.*
6.4.5 Take the prescription to Triage for patient pick-up.

6.5 Provide patient instructions:

6.5.1 Tell patient to come by Triage window to pick up the prescription for the recommended further diagnostics.
6.5.2 The Emergency Department *Follow-Up/Patient Consultation for Lab and X-Ray Reports Form* gets placed in the patient record when completed.

RESPONSIBILITY:

Charge Nurse, LVN, Mid-Level Provider, Emergency Physician

PROCEDURE:

None

APPROVED:	Christine Wiese, Director	Trudi Stafford, AVP Nursing
DATE:	6/22/2005	6/27/2005

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit E

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

WENDY GUZMAN, INDIVIDUALLY AND AS NEXT FRIEND OF [redacted] GUZMAN, A MINOR	)	
	)	CIVIL ACTION NO. 07-3973
V.	)	
	)	JURY DEMANDED
MEMORIAL HERMANN HOSPITAL SYSTEM, D/B/A MEMORIAL HERMANN SOUTHEAST HOSPITAL	)	

****

ORAL AND VIDEOTAPED DEPOSITION OF

PHILIP HAYNES, M.D., Ph.D.

January 18, 2008

Volume 1 of 1

****

ORAL AND VIDEOTAPED DEPOSITION of PHILIP HAYNES, M.D., Ph.D., produced as a witness at the instance of the Plaintiffs, and duly sworn, was taken in the above-styled and numbered cause on the 18th of January, 2008, from 9:45 a.m. to 1:25 p.m., before Connie H. Lindsay, CSR, in and for the State of Texas, reported by machine shorthand, at the law offices of Callaway & Brennig, Three Allen Center, 333 Clay, Suite 4510, Houston, Texas, pursuant to the Federal Rules and the provisions stated on the record or attached hereto.

Page 18

A. -- counts.
Q. In terms of the values that are present on Exhibit 1, are those correct values as compared to Exhibit 2 so far as it goes?
A. Are you asking me are they identical values?
Q. Yes.
A. Yes, sir, they are.
Q. Okay. Here's the question: When you were seeing [redacted] on February 12th of '06, were you aware of those differential white cell count values?
A. No, sir, I was not.
Q. And what explanation do you have for why you were not aware of those white cell count values?
A. At -- as I remembered that day, I -- when I looked at the lab values for Mr. Guzman, the -- the only values I remember seeing were the -- the results of the CBC: the white blood cell count, the hemoglobin, hematocrit and the electrolytes. And when I looked at the time, the differential count was not there.
Q. Okay. Would it be possible for you to take a pen, I guess -- I've got a red pen here, I believe. If you would, take a red pen and on Exhibit No. 2 put a check mark by those values that you believe that you did actually see on February 12th.
A. By each one?

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Q. Yes, please.
A. (Complies)
Q. Have you done that?
A. Yes, sir.
Q. May I take a look at that, please?
A. (Complies)
Q. Thank you.
So would it be fair to say that you saw the hemogram but not the differential on February 12th?
A. Correct. The -- the total white blood cell count, the hemoglobin, hematocrit and the platelet count but not the differential.
Q. Okay. Now, had you ordered the differential?
A. I didn't order the differential specifically, it just comes as part of the complete blood count.
Q. Okay. So when you circle complete blood count on the physician order page, you're ordering not just the hemogram, you're also automatically going to get the differential values from that order.
A. Correct.
Q. Okay. So here's the question: Why didn't you get the differential information that day?
A. Are you asking me why I didn't see the differential or why it didn't -- why it wasn't presented to me?

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Q. We'll go with the first part, why you didn't see the differential, number one.
A. Okay. Well, I -- on that day I evaluated Mr. Guzman. I believed he was -- he complained about nausea and vomiting and I believed he was suffering from a viral-type syndrome. Based on his clinical picture -- excuse me -- based on his clinical progression that day, based on the laboratory values I had available to me at that time, I felt he was stable for discharge. And I did not see that differential count --
Q. Okay.
A. -- before I discharged him.
Q. All right. Is the reason that you didn't see the differential count because you didn't look for the differential count before you discharged him?
A. No, sir. The reason I didn't see it when I -- when I looked at the lab values -- I think it was sometime around 10:00 o'clock in the morning -- the differential values were not there on the computer.
Q. Okay. Did you make any inquiry about the differential values when you decided to send [redacted] home?
A. No, sir, I did not.
Q. In looking at the differential values here today as shown on Exhibits 1 and 2, do you agree with me

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that the differential on [redacted] is abnormal?
A. Yes, sir, I do.
Q. And how would you characterize the degree of abnormality in that differential that you see on [redacted]
A. I don't know that I would be able to specifically say there degrees of abnormality other than to say that it is abnormal.
Q. Okay. Does that differential show what is called a left shift?
A. Yes, sir, it does.
Q. Okay. At any time on February 12th of '06, did anyone from the laboratory department ever call you and talk to you about these lab values on [redacted]
A. No, sir, no one did.
Q. On the morning of February 12th of '06 at Memorial Hermann, did any member of the staff in the emergency department contact you about these differential white cell count values on [redacted]
A. No, sir, no one did not.
Q. Okay. Did Frank Blain ever discuss with you any of the blood work on [redacted]
A. No, sir. He didn't discuss the -- that specific values. He did ask me if I'd taken a look at them before the patient was discharged home. He -- he

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was the one who came to me and said that the family was wondering what the lab values were and -- and what our plan was for him. But he didn't look at those values specifically. He didn't question me about the specific values.

Q. Okay. Well, let's break this down, then. Sometime around -- between 10:00 and 10:15 on the morning of February 12th of -- of '06 you have a conversation with Frank Blain.

A. Correct.

Q. And the conversation with Frank Blain is from the family -- he's relating that the family wants to know what the lab results were.

A. If I remember correctly, he -- he came to me and -- and said that the family was wondering what our plan was for them, mentioned that they were interested in going home and -- and wanted to know if he could pull out the IV.

Q. Well, you told me in a previous answer that you had a discussion with him about the lab values prior to discharge.

A. I believe -- I believe that's not correct. I -- I spoke with him. He was wondering what the lab values were, but he didn't ask me specifically what they were. In other words, he -- he told me that the family

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wanted to know what our plan was. It wasn't specifically, Hey, what are these lab values? What are they -- what do they mean? He didn't speak to me about specific lab values at all. He just wanted to know what the plan was and if I was ready to send him home. And -- and I told him to hold on, I was going to come talk to the family about those values.

Q. Did you know at the time that you were discussing this with Frank that you didn't have the differential back?

A. Yes, I did.

Q. Okay. And so is it true, then, that you made the decision to discharge [redacted] knowing that the differential values had not come back and you hadn't seen them?

A. Yes, I did.

Q. Okay. And would you give us your reasoning for making the decision to discharge [redacted] knowing that the lab values for the differential had not come back?

A. Certainly. I -- I can tell you that when [redacted] presented that day, he -- you know, as I said before, I think I mentioned that -- he was complaining of nausea and vomiting. His mother told us that he was suffering from a -- a cough also. And based on his

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clinical picture at that time went -- you know, I went in and did a whole physical exam on him, interviewed him and talked to his parents. Based on that information, based on the fact that he was clinically stable, his saturation on room air was normal. He had clear breath sounds bilaterally, had no retractions, was in no respiratory distress. I believe we gave him a fluid challenge by mouth to make sure that he was no longer vomiting. And based on all that and the fact that the family wanted to go home, he -- when I went in to see him, I was the one who took out his IV personally and he was telling me he was no longer hurting anywhere other than the place where his IV was and he was comfortable going home. The family was comfortable going home. His -- his saturation remained normal on room air. His heart rate had decreased, initially it was a little high. We gave him a fluid bolus. And based on all that information and on the lab information I had available to me at that time, I felt he was stable for discharge.

Q. If you had actually received the information about the differential white cell count that's reflected in Exhibits 1 and 2, what would you have done?

A. Based on this differential, I would have gone back and reevaluated the patient, I would have told the family members about the abnormal values, I would have

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contacted his primary care physician -- I believe is Dr. Hung -- and I would have admitted him to the hospital.

Q. Would you have given him antibiotics if you had known about the differential?

A. I -- I think I would have contacted his primary care doctor and discussed the case with him and seen what he wanted to do. I think it would be reasonable based on his clinical presentation, the way he looked that day, to withhold antibiotics pending further evaluation; but it -- you know, we -- we might have given him antibiotics also.

Q. As part of the evaluation, the additional evaluation, would that have included a chest X-ray?

A. I don't think at the time the way he presented that a chest X-ray was necessarily indicated. If -- if -- if Dr. Hung had requested one, we certainly would have done one.

Q. Okay. What additional evaluation do you believe you would have done in the emergency department that day?

A. Probably would have sent a blood culture on him also.

Q. Are you able to tell me from your recollection -- pardon me -- about what time it was that

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you looked at the computer to verify the laboratory results on [redacted] that morning?
A. I -- I believe, from my recollection, that it was around -- sometime around 10:00 a m. because I'd already seen Mr. Guzman and ordered those tests and was other -- seeing other patients when Frank Blain came to me and asked me roughly around 10:00 o'clock if he could pull out the IV because Mr. Guzman was telling him that he was feeling better. And I said at that time that I -- I told him, Hold on. Let me look at the lab values and I'll come talk to the family and make sure he's doing better and reevaluate. I believe that was around 10:00 a m.
Q. Okay. Do you see in the note that is on Exhibit No. 2 that there is a footnote added by the laboratory about these values, that the differential -- the manual differential was performed at 9:35?
MR. BRENNIG: Objection to form.
MS. BRYAN: Form.
Q. (By Mr. Pfeifer) Okay.
A. I -- I do see that. But there's often a differential -- in other words, a time discrepancy. I'm not sure if that's exactly the time that they entered the orders or what; but I can tell you when I looked at the lab results on the computer at that time, sometime

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around 10:00 a.m., that that was not there.
Q. Okay. So, what I want to do is back up now and try to understand and get you to explain how it is that blood is drawn in the emergency department, sent to the lab and how lab results get back to the emergency department in February '06 at Memorial Southeast.
A. I'm not clear on your question. Are you asking me how -- how we draw the blood and how the results --
Q. Not -- not the details. I'm -- I'm not asking about where you stick the thing and where -- how you attach a syringe and how you obtain. I'm talking about generally the processing. Let me break it down.
A. Okay.
Q. All right. Where is the lab?
A. I believe it's upstairs on the second floor.
Q. The same building you're in?
A. It's in the same building but on a different floor.
Q. Okay. Is there a dedicated emergency department there at Memorial Southeast?
A. There's a dedicated emergency center --
Q. Okay.
A. -- yes.
Q. All right. And in the same building upstairs

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on the second floor is the laboratory for the hospital.
A. Correct.
Q. When you get blood samples from the emergency department from a patient like [redacted] -- and all these questions are now going to be about February 12, '06. Okay?
A. Yes, sir.
Q. All right. At that point in time when blood is drawn from a patient like [redacted] tell me how that blood gets from the emergency department to the lab.
A. Actually I don't really know the answer to that question.
Q. Okay. How does the order get entered for the laboratory department to know what to do with the blood they receive?
A. All I can tell you -- I'm not sure if I know the answer to that question either. All I can tell you is that when I order tests, I -- I circle different boxes on our order sheet and I give that to either the unit clerk or the nurse and they are the ones that enter those orders in the computer.
Q. Okay. Is Exhibit No. 3 a copy of the order sheet that you signed with regard to [redacted] on February 12, '06?
A. Yes, sir, it is.

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Q. All right. Is Exhibit 4 an enlargement of the portion of the order sheet that you just looked at with regard to the order for blood for [redacted] on that day?
A. Yes, sir, it is.
Q. Okay. Now, when you circle this order "CBC," it was your understanding at that time that someone would take that information and make the actual physical request to the lab for what you had ordered. Correct?
A. I'm not sure I understand your question.
Q. Okay.
A. Your -- I --
Q. You've -- you've circled "CBC" on this page, the order sheet, Page 3. Okay? Correct?
A. Yes, sir.
Q. Now, who takes this order sheet and tells the lab what needs to be done?
A. Oh. It's either the unit clerk or if we don't have a unit clerk working that day, it's the nurse.
Q. Okay. So either a unit clerk, who is a -- basically a medical secretary, enters information or the nurse enters information. Correct?
A. Correct.
Q. And is that information entered into a computer?
A. I believe it is.

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A. -- that day?
I think the -- I would have to say that the sodium level being minorly low, probably not a big deal. And I think his glucose as well, probably just related to is albuterol use and the fact that he was ill, having had a fever and cough.
Q. Okay. Would you go to the exhibit, then, that has the hemogram on it. You've indicated by red check marks that you saw certain laboratory values that day. Correct?
A. Correct.
Q. Okay. Would you go back to Exhibit 4, the blowup of the lab value grid. Is there a --
A. Correct.
Q. -- place in there where one would routinely enter the results of the hemogram on the medical record?
A. Yes, there is. There is a -- a little stick mark. I'm not sure exactly what the technical term for that is.
Q. Okay. Let me give you a red pen and have you circle the area you just described as the "stick mark".
A. (Complies)
Q. Now, do the emergency physicians such at yourself customarily chart in that little stick mark that you've circled there?

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MR. BRENNIG: Objection, form.
A. Yes, sir. We do.
Q. (By Mr. Pfeifer) Okay. In your training were you taught to mark in that area?
MR. BRENNIG: Objection, form.
A. Actually, no. I wasn't really taught in my training to mark there. It just becomes a -- a habit.
Q. (By Mr. Pfeifer) A habit.
A. Just doing it day after day.
Q. Okay. And what material do you routinely enter in each part of the stick mark?
A. Well, on the -- on the leftmost portion, you would enter the white blood cell count.
Q. Okay.
A. And the top portion, you'd enter the hemoglobin. The bottom portion would contain the hematocrit. And then the rightmost portion would be the platelet count.
Q. Okay. And so on this particular day, did you enter any of those values at all on this diagram?
A. No, sir, I did not.
Q. Okay. Did you make any entries of any abnormal values from the hemogram?
A. No, sir, I did not.
Q. Were there abnormal values from the hemogram

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that you saw on the day that [redacted] was in the emergency room?
A. Yes, there were. He had an elevated red -- red blood cell count. He had a -- a low mean corpuscular volume, or MCV. And he had a low mean corpuscular hemoglobin.
Q. Okay. Did you ever enter any of those abnormal values onto this order sheet, Exhibit 3, which we've blown up as Exhibit 4?
A. No, sir, I did not.
Q. Okay. Is there any document at all in the medical record that you can point me to, any entry made by you or anyone else that would -- you would point to as evidence that you had actually seen the hemogram on the day that [redacted] was in the emergency department?
A. Well, I -- I would point to this right here because I -- it was in -- within normal limits except. And those four values that we usually record there were normal and that's why I did not record them there.
Q. Okay. Is there any other piece of paper in the emergency room chart that you feel that you can point to that would suggest and provide evidence, documentation, that you actually saw the hemogram on the day that [redacted] was in the emergency room?
A. No, sir. It would be this -- this paper right

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here.
Q. Okay. And that paper would ordinarily be blank anyway because the values that you would enter in those four little areas on that grid were normal on the hemogram. Correct?
A. Correct.
Q. Okay. Now, with regard to the abnormalities that are shown on the hemogram, they relate to the total red blood cell count, the MCV and the MCH. Correct?
A. That's correct.
Q. What does an elevated red blood cell count indicate?
MR. BRENNIG: Objection, form.
MS. BRYAN: Form.
A. It can mean a lot of different things. In -- in general, it just means that -- one of them is that you could be hemoconcentrated, meaning you're a little dehydrated; but there are many others.
Q. (By Mr. Pfeifer) Okay. Was the red blood cell count elevated?
A. Yes, sir, it was mildly.
Q. Okay. What is MCV?
A. MCV is -- stands for mean corpuscular volume. It's basically the size of the cell.
Q. And what is MCV used for by physicians to

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computer for the management of the emergency department as opposed to the overall hospital system computer?

MS. BRYAN: Can you repeat the question?

MR. PFEIFER: Is there a separate computer for this QualChart System that he's talking about as compared to the overall computer for the hospital?

A. I think --

MS. BRYAN: Form.

A. -- from what I remember and I haven't worked at Memorial Southeast since June of last year, but I think that we -- we had multiple different computers. And one of them was a QualChart computer that also, I believe, had some patient tracking software on it. And then there's other computers we used to look up laboratory values.

Q. (By Mr. Pfeifer) Okay. I guess what I'm trying to find out is this: When you went to look at the laboratory values on the computer, is -- tell me what information is on that computer.

A. You mean the different programs that are on it or -- because it's usually one computer that has different software applications. There'll be one that's a QualChart, you can print that out. You could go to another one and -- and look at patient tracking data and

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another one to access the lab value.

Q. Okay. So, there's one set of programs for this QualChart System that you've talked about and then there's a different set of programs that would allow you to have access to the computerized laboratory and medical record information.

A. I believe that's correct.

Q. Okay. And you believe that the software for both of those programs are on the same computer.

A. I actually don't know. I'm suspecting they are.

Q. Okay.

A. But I don't remember because I haven't worked there since June.

Q. Okay. Back when you were working there, did they have multiple computers that people could use or was there just one in the ER?

A. No, sir. There were multiple computers.

Q. Okay. Was there one that was dedicated for the physicians to use and one that was dedicated for the nursing staff or how did that work?

A. There was a separate nurses station set of computers. We all kind of, as you migrate around, use different computers; but -- but for the most part the -- there's the physician area that has two physician

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computers and then there's other, like, radiology viewing program there. So we used multiple different computers.

Q. Okay. Well, I guess here's the question that I have. We've -- we've seen Exhibit 1 which appears to be the printout of a computer screen. That was the very first exhibit that I gave you.

A. Correct.

Q. Does that computer screen look like the kind of computer screen that you would have had back at Memorial Southeast in '06 to look at this patient data?

MS. BRYAN: Form.

A. I -- I believe from my memory that it does look similar to what we used, but different -- sometimes there are different -- different times on there.

Q. (By Mr. Pfeifer) Okay.

A. Different -- different number of columns.

Q. Okay. But the access to that particular patient information system as reflected on Exhibit No. 1 would be something that the physicians have access to and the nurses have access to.

A. I'm not certain --

MS. BRYAN: Form.

A. -- if the nurses have access to it, but I know that the physicians do.

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Q. (By Mr. Pfeifer) Okay. Where do the nurses enter the computerized nursing notes?

A. At their computers in the nursing stations.

Q. There appear also to be some computerized typing with your initials associated with it in the chart.

A. I -- I did see some of that and I'm not sure how -- how that came about because I don't -- they use a -- it's a separate system. I'm not sure what that designates. There were a few ph1's that refer to me --

Q. Yeah.

A. -- as I recollect. But that -- that's not my access in the computer at that time. That's just somebody making a notation, I presume, that I was in the room or something at that time.

Q. Okay. So, if we look in the medical records and we see the notation "ph1," is that something that you typed into the computer or somebody else did with your initials?

MS. BRYAN: Form.

A. I don't know.

Q. (By Mr. Pfeifer) Okay.

A. Don't know the answer to that question.

Q. All right.

A. I did not -- I know that I did not write that.

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the laboratory results and the X-ray results and that sort of stuff on it and the QualChart paper forms.
MS. BRYAN: Form.
A. The QualChart paper forms are just used to generate a QualChart just for the patient encounter. After that, there are no results in it at all. It's just a -- that's the initial chart you pull out when you see the patient's chart sitting in the rack.
Q. (By Mr. Pfeifer) Okay. Well, I -- I understand that; but then you go in and you make your notations on it.
A. On the chart that you printed out, yes.
Q. Okay. So when you're making the decision as to whether or not the patient should be discharged, what you will have is your handwritten notes that you've made on the preprinted QualChart form and access to the computer with regard to the lab data.
A. Correct. And we usually --
MS. BRYAN: Form.
A. -- enter the lab data that we have on the QualChart.
Q. (By Mr. Pfeifer) Okay. Now, you've told me that the original encounter -- the first encounter occurred about 8:00 --
A. Yes, sir.

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Q. -- ballpark. 8:00 to 8:15, somewhere in that range.
A. Yes, sir.
Q. The second encounter, when did it occur?
A. I don't really know if I could pinpoint a specific time, but -- what -- I -- I can tell you from my usual practice what I do is I -- I stop by people's rooms as I'm going back and forth through the emergency center, poke my head in, ask them how they're doing and -- and -- and sometimes answer questions, things of that nature.
Q. All right. And so are you able to pinpoint the time of the second encounter?
A. I -- I really can't.
Q. Okay. Do you believe it would have been the kind of encounter where you're just poking your head back in and asking how the patient's doing?
A. Yes.
MS. BRYAN: Form.
A. I sometimes ask -- you know, make sure that he's getting fluids and see what's been done and, Have they done this yet, you know, Have they start your IV, things of that nature.
Q. (By Mr. Pfeifer) Okay. And is the third encounter for [redacted] the one that occurred prior to the

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time of discharge?
A. Yes.
Q. 10:00 to 10:15, in that range.
A. Yes.
Q. Okay. When do you believe is the first time on that morning that you saw any laboratory values?
A. I believe it was around 10:00 a m.
Q. Okay. And you had -- according to the nurse's note entry, it looked like the orders for the lab work were entered at about 8:35 -- 8:34, 8:35. Does that sound about right to you?
A. Yes, it does.
Q. Okay. You, by that time, had completed the history and physical of the patient.
A. Correct.
Q. And you had completed the orders for the lab work that you wanted done by that time.
A. Correct.
Q. Okay.
A. We usually ordered the things after I come out of the room and after I talk to them.
Q. You, as the physician, obviously are the person who makes the decision about whether or not further evaluation needs to be done or whether the patient needs to be transferred or whether the patient

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is okay to go home or whether the patient needs to be admitted. Correct?
A. Correct.
Q. Okay. And you did not make that decision until around 10:00 o'clock.
A. Or a little bit after, probably around 10:15.
Q. Okay. Because you needed to get the laboratory data back in order to make that decision and complete your screening exam.
A. Right.
MR. BRENNIG: Objection, form.
MS. BRYAN: Form.
A. Plus I also needed to go reevaluate the patient and discuss his case with his parents and -- and with him, see how he's doing.
Q. (By Mr. Pfeifer) Okay. This is an off-the-wall question. You appear to be a relatively young man. Do you have kids?
A. Yes, sir, I do.
Q. Back in '06, how many kids did you have?
A. I believe I had three.
Q. Okay. The reason I'm asking this is that my client, Mrs. Guzman, has given testimony about the patient encounter with you and that there was a discussion that she had with you related to one of your

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Q. And I can't read what you've got under there.
A. Phallus normal.
Q. Okay. All right. "Medical Decision Making". There's a box there that has "Differential Diagnoses".
A. Correct.
Q. And you circled a bunch of things on there. What does it mean by circling those things?
A. Well, everybody may be different; but when I use this form, I circle things that I consider likely possibilities, things that may be happening.
Q. Okay.
A. And -- and in his case I didn't suspect that he had diabetes, but I thought it might be possible because he had a family history of it and had been having vomit. So I circled that --
Q. And is that --
A. -- for example.
Q. And is that the reason that when he was sent home, you included in the discharge instructions to follow up with the family doctor about whether or not he had diabetes?
A. Oh, yes. Correct.
Q. Okay. Gastroenteritis, did you consider that as part of your differential diagnosis?
A. Yes, I did.

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Q. Okay. And --
A. Because he had been vomiting.
Q. Okay. You also included "Pyelonephritis/UTI".
A. Right. That was an error on my part. I was thinking it was URI, which would be an upper respiratory infection.
Q. Okay.
A. So I didn't consider his symptoms consistent with a urinary tract infection at all.
Q. Okay. So you -- even though you circled that, you -- that was a mistake.
A. Correct.
Q. Okay. And then "Other: Viral syndrome." Correct?
A. Correct.
Q. Did you feel that the viral syndrome was related to one particular organ system or multiple?
A. Well, I -- I believe it was mostly upper respiratory. And then you can also have involvement of the GI system because a lot of times patients are swallowing mucus and that makes them nauseated and you'll throw up. So there can be involvement of multiple organ systems from one disease, but I thought it was primarily respiratory.
Q. Okay. So you thought that he had a viral

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respiratory syndrome that was secondarily causing his vomiting.
A. I -- I believe so. It's -- it's -- it's tough to say. You can have both going on at the same time, too.
Q. Okay. All right. Under the "Re-Evaluation" over there on the right side of the page, you've got the time, 10:13 --
A. Right.
Q. -- recorded. "Improved". And then under that you have something written in, "NR". What does that mean?
A. That's actually "HR".
Q. HR.
A. Stands for heart rate. And what I usually do -- my usual practice I'll write -- and this was written after I reevaluated him before we discharged him. And I'd gone in to assess him and noticed that his heart rate had decreased and his blood pressure was good, his -- his heart rate was lower. And I meant to write heart rate decrease with a down arrow there. But for some reason -- I may have been distracted or -- what happens frequently ER nurses come in, throw an EKG in my face or ask me to come see somebody. So it may have been that I just didn't get a chance to finish that. I

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might have been interrupted and I never went back and filled that in.
Q. All right. Did you ever make any notations about his pain scale?
A. I believe I did at the beginning. Actually, no, I did not. I just -- I -- I basically assessment that he had pain.
Q. Okay.
A. And I know the nurse did.
Q. Okay. Anybody ever reassess his pain and record a scale?
A. No. I -- I reassessed his pain, but I did not reassess a scale on it.
Q. Okay.
A. I went in and asked him a little bit before I wrote that last note where I wrote "HR" at 10:13 if he was hurting anywhere. He told me he was not -- the only place he was hurting was with his IV and he wanted me to take that out.
Q. Okay. Did you give him any treatment for his respiratory condition?
A. No, I did not.
Q. And was the hydration that you gave him to try to treat the heart rate issue?
A. Right. I remember I mentioned earlier I

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Q. And that did not make a difference in your decision to discharge [redacted] on February 12th.
A. Can you rephrase your question? I'm not sure what you meant by that.
Q. Sure.
We -- it's -- we've already asked and answered it, so it's just repetitive. But --
A. I know.
Q. The fact that --
MR. PFEIFER: Okay. Then we object.
Q. (By Ms. Bryan) The fact that the differential had not yet -- either had not yet been completed or you hadn't yet seen it did not affect your decision to discharge [redacted]
A. No, it did not.
MS. BRYAN: Those are all the questions I have at this time.
Thank you, Dr. Haynes.
THE WITNESS: Thank you.
FURTHER EXAMINATION
BY MR. PFEIFER:
Q. Have you ever spoken to Ms. Bryan other than on the record here?
A. No, sir, I have not.
Q. Ever been in a meeting with her?

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A. No, sir, I have not.
Q. Okay. Let me see if I understand something here. Are you saying that it is your routine practice as an emergency physician to disregard white cell counts differentials?
MS. BRYAN: Objection, form.
MR. BRENNIG: Objection, form.
A. No, sir, it's not.
Q. (By Mr. Pfeifer) If you have differential white cell count information, do you consider that information in evaluating the patient?
A. Yes, sir, I do.
Q. If you have the white cell count differential information, do you consider that as part of your medical screening examination of the patient?
MS. BRYAN: Form.
A. No. I don't believe it is part of the medical screening exam.
Q. (By Mr. Pfeifer) Why not?
A. Because a medical screening exam is -- is part of an exam done to determine if medical -- emergency medical condition exists. But that's a screening exam. I'm not sure if that's different from the exam that we do in the emergency center. Those are two different things, I think.

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Q. Do you know what the legal definition of a medical screening exam is?
A. I'm not familiar with that, no. Not completely.
Q. All right. Let's put it in plain terms, then, rather than legalese. If you have the results of the white cell count differential on a patient, do you consider them in evaluating what you do with the patient?
MS. BRYAN: Objection, form.
A. Yes.
Q. (By Mr. Pfeifer) Okay. And are you saying that if you had the results in this particular case, you would have disregarded them?
MS. BRYAN: Form.
A. No, sir, I'm not.
Q. (By Mr. Pfeifer) Are you saying just the contrary? If you had the results, you would have taken different action?
MS. BRYAN: Objection, form.
A. Yes, I would.
Q. (By Mr. Pfeifer) Okay. Now, is it your testimony here today that you routinely do not look at the results of differentials even if they are reported?
MR. BRENNIG: Objection, form.

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MS. BRYAN: Form.
A. No, that's not what I'm saying. I routinely look at all labs available to me.
Q. (By Mr. Pfeifer) Okay. And the routine at the emergency room at Memorial Hermann Southeast is for all labs to be reviewed by the physician --
MR. BRENNIG: Objection --
Q. (By Mr. Pfeifer) -- prior to discharge. Correct?
MR. BRENNIG: Objection -- objection, form.
MS. BRYAN: Form.
A. I don't know if that's a routine. I think it just differs on a case-by-case basis.
Q. (By Mr. Pfeifer) Okay. The white cell count differential in a patient, can you have a normal total white blood cell count and have an abnormal differential?
A. Yes, you can.
Q. When did you first learn that?
A. Probably in medical school.
Q. Okay. And have you continued to have that knowledge throughout your practice of emergency medicine?
A. Yes.

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Q. Is it true that a normal white cell count does not necessarily rule out a bacterial infection in a patient?
A. Yes, that's true.
MS. BRYAN: Form.
Q. (By Mr. Pfeifer) Okay. Is it the routine at Memorial Southeast that if a CBC is circled on a chart in the emergency department, that patients are sent home from the emergency department and discharged prior to physicians seeing the white cell differential?
MR. BRENNIG: Objection, form.
MS. BRYAN: Form.
A. I'm not aware -- I don't believe that it's routine. It just, again, depends on the case-by-case basis. Depends on all the circumstances.
Q. (By Mr. Pfeifer) Okay. What good does it do to have a white cell count differential generated for evaluating a patient if the doctor never sees it?
MR. BRENNIG: Objection, form.
MS. BRYAN: Form.
A. I'm not sure I understand the -- the wording of your question. Just -- what good does it do --
Q. (By Mr. Pfeifer) Yes.
A. -- to have it if it's not --
Q. Seen by the physician.

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A. -- seen?
I guess in that -- if it's not seen by the physician, it doesn't do any good.
Q. Okay. And you've previously told me that when you circle CBC, you routinely get the total white cell count, the differential and the platelets. Correct?
A. Yes, that's true. When you circle CBC, part of the -- part of the evaluation is the hemogram and then part of it's the differential.
Q. Okay. That is the routine of the hospital. Correct?
A. I don't know if that's a routine of the hospital, but that's a -- a routine of the lab values. When you order that, you get that complete blood count evaluation.
Q. At the emergency room.
A. In the emergency center, yes.
Q. Okay. And so that is the routine in the emergency center.
A. I believe so. Yes.
Q. Okay. And in this particular case, the routine would be to expect to get those results for the patient before the patient is sent home.
MR. BRENNIG: Objection, form.
MS. BRYAN: Objection, form.

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A. Not necessarily. Again, that kind of depends on the whole clinical circumstances on a case-by-case basis.
Q. (By Mr. Pfeifer) In this particular situation, information that was routinely ordered for [redacted] Guzman was not completed by the time the patient was discharged. Correct?
A. Correct. Well, actually, I -- I don't know if I can answer that question. I don't know if it was completed or not.
Q. Okay. But it wasn't completed in the sense that the physician knew the information. Correct?
A. All I could say is that I wasn't aware of that information prior to discharge.
Q. Do you routinely discharge patients that have white cell count differentials ordered on them without knowing the white cell count?
MR. BRENNIG: Objection, form.
MS. BRYAN: Form.
A. No -- no, I don't.
MS. BRYAN: I think you misspoke, Phil. You meant to say --
Q. (By Mr. Pfeifer) Okay. Do you routinely --
MR. BRENNIG: You've already asked that question four times.

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Q. (By Mr. Pfeifer) Do you routinely discharge patients who have white cell differentials ordered and you don't know the results?
MR. BRENNIG: Objection, form.
A. No, I do not.
Q. (By Mr. Pfeifer) Okay. Did you ever make a complaint to the laboratory director about the failure to get the lab results?
MS. BRYAN: I'm going -- to the extent that there were any complaints made that would be part of a peer review, quality review, performance improvement, medical committee complaint, I'm going to assert the privilege of the hospital and instruct Mr. Brennig to instruct his witness not to answer.
MR. BRENNIG: Don't talk about anything if it's related to any of those matters she just listed.
Q. (By Mr. Pfeifer) Any of the committees.
A. I didn't speak --
MS. BRYAN: Part of an investigation of any of those committees.
A. I'm not sure how to answer that under those constraints.
MR. BRENNIG: Well, if it --
A. I mean --
MR. BRENNIG: If you had -- if any -- had

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit F

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

WENDY GUZMAN, INDIVIDUALLY AND NEXT FRIEND OF [redacted] GUZMAN, A MINOR	:	
	:	CIVIL ACTION NO. 07-3973
V.	:	
	:	JURY DEMANDED
MEMORIAL HERMANN HOSPITAL SYSTEM, D/B/A MEMORIAL HERMANN SOUTHEAST HOSPITAL	:	

* * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF
DOUG MITCHELL
November 12, 2008

* * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF DOUG MITCHELL, produced as a witness at the instance of the Plaintiff, and duly sworn, was taken in the above-styled and numbered cause on the 12th day of November, 2008, from 9:54 a.m. to 11:53 a.m., before Gretchen C. Dowda, CSR in and for the State of Texas, reported by machine shorthand, at the offices of Smyser, Kaplan & Veselka, LLP, Bank of America Center, 700 Louisiana, Suite 2300, Houston, Texas 77002, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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one flag is positive; and the verify -- the VER means verify. It is -- this is not a chartable result. This is for the use of the technician only.
Q. Okay.
A. This would not be visible to the physician attending.
Q. When there is -- is a flag like this at 9:35, is there an audible sound that comes out of the instrument to bring it to the attention of the lab tech that there is the need for positive verification?
A. No. It is on the -- it is just like this. What you're seeing printed here is what the tech would see on the screen.
Q. Okay. Would the tech also see the automated results?
A. Uh-huh.
Q. Okay.
MS. BRYAN: Say "yes" or "no." You said "uh-huh."
THE WITNESS: Oh, I'm sorry.
A. Yes.
Q. (By Mr. Pfeifer) Okay. And if the tech then proceeds to a manual differential, what happens to the automated data that was generated with regard

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to that lab test?
A. It is overridden. Gone.
Q. It's gone.
Okay. And the only result that remains, then, would be the manual results that are recorded by the technician?
A. Right.
Q. Okay.
A. Now, the printout from the instrument is kept for one week.
Q. Okay. When you say "the printout from the instrument," are you saying that the printout of the results of the man -- of the automated differential would have been available at the hospital for one week and routinely kept for that period of time?
A. Right.
Q. And after one week it is thrown away?
A. (Witness nods head.)
Q. Is that "yes"?
A. Yes.
MS. BRYAN: Say --
A. Sorry.
Q. (By Mr. Pfeifer) So in this particular case it would be impossible to go back and get the actual results of the automated differential at this

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time?
A. Yes.
Q. Okay. Then on line 8 we have MSW. Again that's Mina Suzanne Wagner, at least according to how the hospital had it recorded?
A. Yes.
MS. BRYAN: Is it Suzette or Suzanne?
MR. PFEIFER: He's got -- he said Suzanne.
THE WITNESS: It -- you know, it may be Suzette.
MR. BRENNIG: That's her name in the deposition.
MS. BRYAN: I think it's Suzette.
THE WITNESS: Yeah, okay.
MR. BRENNIG: That's her official name.
A. Right. She's been Sue for -- ever since I've known her.
Q. (By Mr. Pfeifer) All right. In any event, Sue is the person who is doing the manual differential, according to this record, correct?
A. Correct.
Q. Okay. And then, again, the time is recorded here as 9:35?

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A. Yes.
Q. Okay. What would the time 9:35 mean?
A. That is the time at which she verified her manual diff. The reason that the M gram 1 crossed at that time is because it is part of the differential field. So it came at that same time.
Q. Okay. Physically how long does it take to do a white cell differential manually?
A. I would say probably the fastest that you could do it -- because you have to make a slide; you have to let it dry, put it on the stainer, which takes five or six minutes, and then sit down and count it and do all that. So a reasonable time is anywhere from 20 to 35 minutes.
Q. Okay. Well, given the times that we have recorded here, would it be fair, in retrospect, to say that probably what happened here is that sometime around 9:11, when they were running the automated processing with regard to this, the flag came up suggesting the need to do the manual differential correct?
A. Correct.
Q. And then between 9:11 and 9:35, a period of about 24 minutes, was probably the period during which Sue was processing and tabulating the manual

differential?
A. Correct.
Q. And then probably at 9:35 -- well, actually, according to this record, at 9:35 she verified the results on the computer system?
A. Correct.
Q. Now, when you used the term "verified on the computer system," what does that actually mean the tech is doing?
A. They're releasing the results. They are saying at that point, I am looking at these results. It's done. It's finished. It's valid. I verify it. It's gone.
Q. Okay. And when you say "I verify it, it's gone," it is being transmitted in the ordinary course of business through the Cerner computer system through the interface into the Hospital Information System?
A. Yes.
Q. Now, on line 12 -- I'm sorry, line 10 of this same page 006 --
A. Uh-huh.
Q. -- it has a notation that gives the normal values for lymphocytes. And then it has 8.0 and it has L and then it has f written by it.

A. Right.
Q. Okay. Why is it that there is supposedly a footnote for lymphocytes and no footnote with regard to segs or bands or monos?
A. The footnote that you're seeing attached to the lymphocytes is a footnote that states -- and that's what we read here -- that a manual differential was performed. That was added several years back; they came up with the suggestion of putting a footnote on the lymphocyte when an auto -- or when a manual differential was performed, because some of the physicians had complained that they did not know whether it was an automated diff or a manual diff. So this is simply a footnote attached to the lymphocytes that says "manual differential performed."
Q. Okay.
A. It is an automated thing and that's why it says "GLM." When you order the manual diff, the footnote comes with it.
Q. Okay. From the standpoint of the technician entering this material, are they pushing certain key strokes on a computer keyboard that will generate this automated footnote?
A. When they say yes to manual diff, when

you're sitting down at your -- when you make the slide and you sit down, you call it up in the differential mode. And at that point you can either say: The automated diff is correct, and you say no and release it and the automated diff goes.
If you say no, I need to do a manual diff, then you say: Manual diff, you perform it, release it, and it goes. And at that time it generates the footnote.
Q. Okay. And the content of the footnote is simply the fact that the manual differential was performed?
A. That's -- that's the sole content of it.
Q. Okay.
A. It could have been attached to anything. They just chose lymphs.
Q. Okay. I'm going next to page 7 of the same document. Can you tell me what information is being generated here in terms of the lab tests that are being run?
A. On this page?
Q. Yes, sir.
A. Page 7?
Q. Yes.
MS. BRYAN: Objection, form.

Phil, I don't understand the question.
Q. (By Mr. Pfeifer) What are the tests that are being run here?
A. Okay. There are no tests. These are simply the results of the manual differential.
Q. Okay.
A. The last three items that you see here is platelet morphology, and the result of microcytes. There were some small red cells.
Q. All right.
A. And then the last one is the response that I mentioned to you that if you say "manual diff, yes," it generates that footnote.
Q. Okay.
A. It's just a back end of the manual differential.
Q. Okay. Turn to page 8. Again, we are in Exhibit 1. There is a line that begins with the word "ordered."
A. Uh-huh.
Q. 2-12-06. And then it says 0831.
A. Right.
Q. ID HIS.
A. Right.
Q. Okay. How is it -- what does HIS mean?

Information System about the order for the lab test for this patient?
A. Yes --
MS. BRYAN: Form.
A. -- they do.
Q. (By Mr. Pfeifer) Okay.
A. That's what is listed here as HIS.
Q. All right. And is that information that they enter in the Hospital Information System in the emergency room about the order for the lab test on this patient transmitted automatically to the laboratory electronically?
A. Yes.
Q. Okay. Then -- but you don't -- you don't know about that or try to match it to anything until you receive the blood through the pneumatic tube?
A. That's correct.
Q. And so when the blood is available in the lab, the tech would take the pneumatic tube, they would look up the patient number on the specimen and it would be in the computer and they match it to make sure it's the right person and the right test?
A. That's right.
Q. Okay. So unless there is an override of some sort, the information here about the order and

the draw time would be data that were entered into the computer in the emergency room?
A. That's correct.
Q. And that same data would be available to you through the Cerner system in the lab?
A. Yes.
Q. Okay.
A. This -- this particular sheet that you're looking at is a Cerner Classic --
Q. Okay.
A. -- sheet.
Q. All right. Now, the line down there, it says "In Lab."
A. Right.
Q. And it gives a time of 8:56. Who is it that makes the entry at 8:56?
A. That -- it's a lab person -- and I did not look this up. I'm not sure who that is. 61685. That's an ID, and I'm -- I don't know. Off the top of my head, I can't tell you who that is. It's easily found out, though.
Q. Okay. In any event, we now know there are three people in the lab. We know there's the person who has the ID 61685.
A. Uh-huh.

Q. We know there is Suzette or Sue.
A. Right, Sue.
Q. And we know there's Ashwa --
A. Asha.
Q. Asha, okay.
In any event, the person that makes the notation of the sample being in the lab is a lab person?
A. Yes.
Q. And they're entering that in to the lab person's computer?
A. Right.
Q. Okay. And what does it say -- mean MC10?
A. MC10 is Southeast designation. All that means is -- the Cerner Classic is a giant main frame and all of the hospital laboratories run off of that with the exception of Hermann, which -- at this time Hermann had their own. But all the other hospitals have access -- or are all fed into the same main frame.
Q. Okay.
A. MC10 is simply southeast designation.
Q. All right. So let's try to put this back into a sequence of events, then, from the records that we have from the Cerner system, okay?

A. Okay.
Q. From the records is it fair to say that sometime around 8:31, the order was entered by a person in the Emergency Room Department for the blood tests for [redacted] Guzman?
A. Yes.
Q. And that the blood was drawn and recorded in the emergency room on the Hospital Information System about 8:33.
A. Yes.
Q. The blood was then placed in pneumatic tubes and sent from the Emergency Department to the lab and --
A. Yes.
Q. -- the blood was received and logged in the lab at 8:56 a m.
A. Yes.
Q. Okay. Then there were different specimens or different tubes of blood for the basic metabolic profile and the CBC, correct?
A. Correct.
Q. Would there have been two tubes of blood?
A. Oh, yeah.
Q. Okay. And so one tube of blood went to Asha, the lab tech, and the other tube of blood went

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to Sue?
A. Right.
Q. Asha used a different device to process the basic metabolic profile from the device that Sue used to do the complete blood count, correct?
A. Yes.
Q. The results of the basic metabolic profile were completed and logged on the Hospital Information -- I'm sorry, the Lab Information System at 9:11 a.m., correct?
A. Correct.
Q. And at the same time, at 9:11 a.m., the results of the overall CBC, but not the differential, were logged on to the Laboratory Information System at 9:11?
A. Yes.
Q. And it's at that point in time that you believe that the flag was probably generated by the Coulter counter to suggest that a manual differential should be performed?
A. Yes.
Q. And after 9:11 and between 9:11 and 9:35 is when Suzette Dalmeida, or Wagner, was actually performing the task of a lab tech in generating and recording onto the computer the results of the manual

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differential test?
A. Yes.
Q. And by 9:35 in the morning she had logged onto the laboratory information system the results of the manual differential test that was done on [redacted] that morning?
A. Yes.
Q. Okay. And you believe that if the system -- the computer system were functioning as it normally would, that those lab results would be instantaneously available on the Hospital Information System from your background knowledge and experience as the manager of the lab?
MR. BRENNIG: Object; calls for speculation, no foundation.
A. Yes.
Q. (By Mr. Pfeifer) Okay. Is Exhibit 7 that I have here -- this is the one about the differential whole blood auto scan manual.
A. I don't have that.
MS. BRYAN: That's attached to --
A. Oh, is that this?
MS. BRYAN: Back of that.
A. Let me get everything organized. All right.

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Okay. What was the question, sir?
Q. (By Mr. Pfeifer) Is this particular document that we have marked as Exhibit 7 here a description of the policy and procedure for when there should be a manual white cell differential performed?
A. Yes.
Q. I'm looking on the bottom of page 134.
A. Okay.
Q. It's the second page of the document.
A. Uh-huh.
Q. And it lists manual differential. And then it says, "a manual differential must be performed when," and it lists a bunch of bullet points there.
A. Uh-huh.
Q. Do you believe that the bullet point that applies is the one that says, quote: Immature cells are seen on the scan such as Metamyelocytes Myelocytes, promyelocytes, Blasts?
A. No.
MS. BRYAN: Form.
Q. (By Mr. Pfeifer) Okay. Can you point me in this document where it is that the particular flag that you described would come into play?
A. Well, the flag comes into play on the

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beginning of the procedure, when it states that you will do a scan if any one of the following occurs. And if you will look down here, this is on that same page --
Q. Right.
A. -- under Category 3, right at the top. If you go down to the --
Q. Right.
A. -- to the very bottom. Any suspect flags for Blast, immature neutrophil 1, immature neutrophils 2, which is the same as immature gran. Granulocytes.
Q. Okay.
A. That's what caused her to scan the slide. The part that caused her to do the manual diff is, if you look two bullet points above where you were originally referring to, it says bands greater than 11 percent.
Q. Okay.
A. So if she makes a slide and she sees estimated more than 11 percent bands, then she, at that point, would stop, order the manual diff, and result it.
Q. As a -- I presume, from background, you're a certified laboratory technologist?

Is an emergency room patient considered to be a hospital registered inpatient?
A. No, they're not.
Q. Okay.
A. This -- this does also -- basically, it's applying to those results that would be verified after the patient was gone. Some tests -- for instance, microbiology tests might take as long as a week or a send-out that has to go to California or somewhere. And that's what this is mostly referring to.
Q. Well, here's -- here's what I'm trying to get at.
A. Okay.
Q. Is there any way the lab knows when an emergency room patient is actually discharged?
A. Is there any way that we know?
Q. Yes.
A. Not in real time, no. I mean, we don't get notification patient is discharged. I mean, at -- if they have placed the patient in a discharge status and sent them home, we can look and see that they are discharged. But we would not normally do that. That information is not something we would normally be looking at when you're resulting tests.

Q. I've heard something called a "callback procedure" with regard to laboratory results that may be reported after a patient has left the Emergency Department. For example, suppose a patient has a test that's ordered and the test is not yet completed and the patient is sent home before the lab result is completed.
What I'm trying to find out is how -- how does it work at the hospital that those results get reported back to the patient, if you know?
MS. BRYAN: Objection, form, over broad.
Q. (By Mr. Pfeifer) Do you know?
A. No, actually. That -- I don't know exactly. But basically, it would be the emergency room that would perform that.
Q. Just so we're clear about it -- this is a different issue, but just so we're clear about, when a manual differential is done, that's done by a human being who is conscientiously making a count or tabulation of the results of a white cell differential, correct?
A. Correct.
Q. So the lab tech at the hospital knows the result of the white cell differential by the time

they post it and verify it on the Laboratory Information System.
A. Yes.
Q. Is there any way that you can tell from the documentation in Exhibit 1, which was the printout of the data, whether or not there were any abnormalities with the functioning of the computer system on the day that all this occurred, February 12 of '06?
A. I can tell that there were none on the laboratory computer system.
Q. Okay.
A. This does not tell me whether there was a problem on the other end.
Q. Okay. At least as far as your half of it is concerned, the Laboratory Information System, you can say that there were no malfunctions from the Laboratory Information System that morning?
A. Well, not at this -- with this particular tests.
Q. Yes.
A. I mean, these are all automated entries that went across.
Q. Okay. I'm now shifting to a different document which is the Critical Value Reporting Process.

A. Critical Value Reporting Process.
Q. Which exhibit number is that?
A. Three.
MR. BRENNIG: Give us the Bates stamp numbers on it, Phil, please.
MR. PFEIFER: Yes. It's 0032, in the bottom corner.
MR. BRENNIG: Thank you.
Q. (By Mr. Pfeifer) Under the policy statement -- first of all, did you have anything to do with drafting these policies?
A. No.
Q. Mr. Faucett looks to be the Vice President for System Laboratory Services. Correct?
A. Yes.
Q. Was he basically your boss?
A. Well, at the end of it, yeah. There were several layers in between. There was a director that I reported to directly at Memorial Southeast. There was a medical director at Memorial Southeast, which is Dr. Floyd.
Q. Dr. who?
A. Floyd.
Q. What's his first name?
A. Craig Floyd.

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit G

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

WENDY GUZMAN, INDIVIDUALLY AND AS NEXT FRIEND OF [redacted] GUZMAN, A MINOR	:	
V.	:	CIVIL ACTION NO. 07-3973
MEMORIAL HERMANN HOSPITAL SYSTEM, D/B/A MEMORIAL HERMANN SOUTHEAST HOSPITAL	:	

* * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF
APRIL GANZ
January 30, 2008

* * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF APRIL GANZ, produced as a witness at the instance of the Plaintiff, and duly sworn, was taken in the above-styled and numbered cause on the 30th day of January, 2008, from 11:58 a.m. to 2:40 p.m., before Gretchen C. Dowda, CSR in and for the State of Texas, reported by machine shorthand, at Smyser, Kaplan & Veselka, L.L.P., 700 Louisiana St., Suite 2300, Houston, Texas 77002, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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Q. Okay. Can you tell me briefly what work experience you've had as a registered nurse between the time you graduated from nursing school up until February of '06?

A. I have predominantly worked in the Emergency Department. During the time I was an agency nurse I took a contract in I.C.U. as well.

Q. Okay. When did you start working for Memorial Hermann Southeast?

A. I have been on staff about five and a half years as a Memorial Hermann Southeast employee and for a year and a half prior to that I worked for an agency where I was regularly assigned to work at the E.R. at Memorial Hermann Southeast.

Q. At this time in February of '06 who did you work for?

A. I worked for Memorial Hermann Southeast.

Q. And you were a paid employee of them, get your W-2 from them?

A. Yes.

Q. And by "them" I mean Memorial Hermann Hospital System.

A. That's correct.

Q. Okay. And what is the name of the agency that you worked at before you worked for Memorial

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Southeast?

A. Hou Staff.

Q. Are you a certified emergency nurse?

A. I am.

Q. Okay. And explain what that means.

A. It means that the Emergency Nursing Association, which is the association for emergency nurses that kind of regulates their practice or makes recommendations on their practice, I have sat before an exam and shown that my knowledge is sufficient to pass the exam of certified emergency nurse specializing in the area of emergency nursing.

Q. Okay. When did you become a certified emergency nurse?

A. I believe it was in 2006, slightly after this took place. After this case took place.

Q. All right. And had you taken the exam prior to -- when did you take the exam I guess is a good question?

A. I took the exam I want to say the end of March or April of 2006. And at this time I had completed the review course, but I had not studied and taken the exam.

Q. Can you tell me what positions that you had held during the period of time of your employment at

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Memorial Southeast?

A. Well, I came on staff as a staff nurse and I currently am a shift supervisor. I have also served as a charge nurse. I work all areas of the Emergency Department and I have other positions, like, I'm the pediatric liaison for the Emergency Department and was at this time. And I also chair the career ladder for the hospital.

Q. That's a lot of stuff. Let's go through them one by one if we can. You told me something about being shift supervisor. Is that nursing shift supervisor?

A. Yes.

Q. And when did you first become the nursing shift supervisor?

A. I would say that I accepted that position about nine months ago. The position was created shortly before then throughout the hospital.

Q. Okay. So nine months ago would be summer of '07?

A. Yes.

Q. What was your position in February of '06?

A. I worked as a staff nurse and did relief charge work.

Q. And on the day that you saw [redacted] the 12th

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of February of '06 were you working as a staff nurse or charge nurse?

A. I was working as a staff nurse and I was assigned to the triage area.

Q. Okay. At that time had you temporarily been assigned to charge nurse duties in the E.R.?

A. I had, but I was not that day.

Q. Okay. Do the different -- do the responsibilities of a staff nurse differ from those of the charge nurse?

MS. BRYAN: Form.

A. Yes.

Q. (By Mr. Pfeifer) Are you able to tell me who the charge nurse was on the day of this visit February 12th of '06?

A. I don't recall.

Q. Where would one go look to find out who the charge nurse was?

MS. BRYAN: Form.

A. I suppose you could talk to the department manager about the records. I'm really not sure. I don't maintain that log.

Q. (By Mr. Pfeifer) Who is that? Who is the department manager?

A. Currently it's Mutlu Smith.

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improvement review, which would be privileged.
THE WITNESS: Okay.
MS. BRYAN: And it's not really relevant to the question. So Phil, do you mind reasking the question?
MR. PFEIFER: Sure.
MS. BRYAN: I'm lost now.
Q. (By Mr. Pfeifer) What sorts of best practice from outside the hospital would be reviewed and considered by the nursing staff? You said that there were several sources of information outside the hospital that are reviewed routinely and considered as part of best practice.
Focusing now on the emergency room only, can you give me some idea where those materials are found?
MS. BRYAN: Objection, form.
A. I think that's kind of vague for me to answer that way.
Q. (By Mr. Pfeifer) All right.
MS. BRYAN: I think --
Q. Help me out.
MS. BRYAN: -- he's asking you if there are any sources outside the hospital that would contain best practices.

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MR. PFEIFER: -- that relate to the Emergency Department, yes. You have phrased it very well.
MS. BRYAN: Thank you. Always here to help.
A. Okay, let me think about that for a minute that relate to the Emergency Department.
Okay, I thought about it.
Q. (By Mr. Pfeifer) Okay.
A. One example might be the revision of our acute myocardial infarction protocol.
(Mr. Brennig left the deposition room at this time.)
Q. (By Mr. Pfeifer) Okay.
A. Organizations outside the hospital made recommendations on what best practice would be and we revised our practice and admission orders for acute MI and response.
Q. Okay. So is there actually a protocol with regard for acute MI at the hospital?
A. Yes.
Q. And tell me what you mean by a "protocol."
A. There is a standard order set that the hospital has agreed upon that meets with best practices. And all physicians try to adhere to those orders unless there is a specific reason why they wouldn't with that case to achieve the best outcome for the patient.

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Q. To your knowledge are there protocols concerning pediatric patients who come in with complaints similar to those that [redacted] had?
MS. BRYAN: Form.
A. We do have protocols in the emergency room that are approved by the medical director that, for example, a nurse may start in triage if they could not get the patient to a room for a medical screening, you know, in which situation it would be the doctor that saw the patient that would order things.
Q. (By Mr. Pfeifer) Any other protocols with regard to standard orders that are to be given with regard to pediatric patients?
A. The only one that I'm aware of specifically in regards to pediatric patients that comes to my mind is there is a protocol to administer Tylenol or Motrin if the child has a fever over a certain range.
Q. Do you know whether there is a protocol with regard to vital signs?
A. There is no protocol that I'm aware of that lists a specific time frame or anything specific about vitals outside of the fact that it is based on the clinical appropriateness of the case.
Q. Are there any protocols with regard to chest x-rays of pediatric patients in the emergency room?
A. I have never seen anything that specific.
Q. Any protocols at all with regard to chest x-rays?
A. I am not aware -- I think there are protocols that include a chest x-ray in the situation, say, for example of the acute MI. That would be included in that protocol.
Q. Okay. Are there protocols that you are aware of that just deal with the general flow of pediatric patients that have medical conditions that come to the Emergency Department?
A. No.
Q. Okay. In your experience would what is necessary for medical screening exam in that circumstance be left solely to the clinical judgment of the physician who was conducting the exam?
A. Are you asking whether the physician conducting the exam would be the one who decided what to order?
Q. Not exactly.
A. Okay.
Q. What I'm asking is whether or not there

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Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit H

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

WENDY GUZMAN, INDIVIDUALLY AND AS NEXT FRIEND OF [redacted] GUZMAN, A MINOR	:	
V.	:	CIVIL ACTION NO. 07-3973
MEMORIAL HERMANN HOSPITAL SYSTEM, D/B/A MEMORIAL HERMANN SOUTHEAST HOSPITAL	:	

* * * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF
FRANK BLAIN
February 4, 2008

* * * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF FRANK BLAIN, produced as a witness at the instance of the Plaintiff, and duly sworn, was taken in the above-styled and numbered cause on the 4th day of February, 2008, from 10:03 a.m. to 12:02 p.m., before Gretchen C. Dowda, CSR in and for the State of Texas, reported by machine shorthand, at Smyser, Kaplan & Veselka, L.L.P., 700 Louisiana St., Suite 2300, Houston, Texas 77002, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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A. That's it. I just -- I couldn't tell you anything specifically about it.
Q. Do you know who it is, if anybody, that is reviewing lab tests that come in that are abnormal after the patient has been sent home?
A. I don't know --
MS. BRYAN: Form?
A. -- who would do that.
Q. (By Mr. Pfeifer) Okay. I'm going to show you Exhibit 2. Is that a copy of the chart for February the 12th?
A. Yes, sir.
Q. Okay. And you have previously reviewed those records, correct?
A. Yes, sir, I believe I have.
Q. Okay. There are notations in there that have been typed in with the letters "fb1" on the pages of that chart. Do you see "fb1"?
A. Yes, sir, I do.
Q. Does "fb1" stand for Frank Blain?
A. I'm assuming that's what it stands for, yes, sir.
Q. Can you tell me whether you have any actual recollection of the events of February 12th with regard to [redacted] Guzman?

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A. Some.
Q. Okay. Is there anything that you remember about [redacted] that is not recorded in the chart here?
A. I don't believe so.
Q. All right. Sometimes after an event people make notes to themselves for the purpose of being able to review them or refresh their memory or something later on. And what I'm trying to find out is whether you ever wrote anything to yourself for your own reference about the events concerning [redacted] Guzman, either handwritten or typed up something, or made any kind of notation at all that you could go back and review to try to refresh your memory about what happened concerning [redacted]
A. No, sir, I did not.
Q. Okay. So if we were to look for any records at all about what happened to [redacted] concerning the interaction you had with him as a patient and the care that was rendered to him, would it be within this chart?
A. Yes, sir.
Q. Okay. No other records you know of anywhere concerning [redacted]
A. No, sir, I didn't.
Q. Okay. I'm just trying to be sure.

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A. Right.
Q. Because sometimes in my past I have encountered that, that sometimes people make notes, okay? That's the reason for those questions.
By reference to the record can you tell me how many times during [redacted] visit to the ER in February 12 that you actually interacted with him or his family?
A. I couldn't tell you a specific number, no, sir.
Q. Do you have any independent recollection of [redacted] vital signs that are not recorded in the chart?
A. Not specifically, no.
Q. Okay. I just want to know all you know about vital signs, because there may be testimony that you can give about recollections that are not recorded in the chart here. Do you understand what I'm getting at?
MS. BRYAN: Objection, form.
Q. (By Mr. Pfeifer) And what I'm trying to find out now is whether you have some independent recollection of [redacted] vital signs that are not reflected here in this chart.
A. It's -- it's possible with vital signs, yes,

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sir.
Q. Okay. Well, tell me what you recall about the vital signs that are not recorded in the chart.
A. I don't recall anything specific.
Q. Okay. Do you recall anything about heart rate that is not recorded in the chart?
A. I don't recall if it was continuous or if it was -- if this was spot. I'm not a hundred percent certain.
Q. How about with regard to oxygen saturation? Do you recall anything about oxygen saturation that's --
A. By the document I do.
Q. Okay. But not independent?
A. Not specifically, no, sir --
Q. The problem I have --
A. -- that stands out.
Q. Let me just tell you what -- what I'm trying to find out here. You may have information about [redacted] medical condition that is not reflected in this medical chart. And when you answer "not specifically," it leads me to believe that there may be something general that you know that I haven't asked the right targeted question for. You follow me?

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And what I'm trying to find out now and make it as global as possible is this: Is there anything about [redacted] vital signs that you can tell us that would add to or supplement in any way from your memory what is recorded in this chart?

MS. BRYAN: Form.

A. No, sir, I couldn't.

Q. (By Mr. Pfeifer) Okay. Did you make entries in the medical chart using the initials "ph1"?

A. No, sir.

Q. Okay. Here's what I'm trying to find out: Ph1 on page 15, MHSE-15, seems to indicate that that is Dr. Phillip Haynes. Okay? And we've taken Dr. Haynes' deposition. And I want you to assume that Dr. Haynes has indicated that he did not make the entries in the chart with the name "ph1" next to them. Okay?

But we know from looking at the record that the entries are there for "ph1." You follow me?

A. (Witness nodding.)

Q. What I'm trying to find out is: Did you make entries for Dr. Haynes in this chart with the name of "ph1" at his request?

A. No, sir. Not knowingly, no.

Q. Okay. And did you make entries in this

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chart at all under the name "ph1"?

A. No, sir, not -- no, sir.

Q. Okay. Do you have any explanation then of how entries were made into the chart under the initials "ph1"?

A. No, sir.

Q. Let's start at 7:55. I'm looking on page 13 of the chart, okay, at the bottom. MHSE-013.

A. Yes, sir.

Q. And it looks to me that that is the first in time note that is made by you concerning [redacted] Does that look to be accurate?

A. Yes, sir, it has my initials by it.

Q. Okay. At 7:55 you wrote that he was crying; is that right?

A. Yes, sir.

Q. So you saw that he was crying?

MS. BRYAN: Form.

A. That's what I documented. I don't --

Q. (By Mr. Pfeifer) Okay. Well, if you documented it, it was true, correct?

MS. BRYAN: Form.

A. I guess. But I don't know in reference to what.

Q. (By Mr. Pfeifer) Why he was crying?

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A. Right.

Q. Okay. Also at 7:55 you have written that he was unable to use the pain scale. Did I read that correctly?

A. Yes, sir.

MS. BRYAN: Form.

Q. (By Mr. Pfeifer) Can you tell me what you meant when you documented that he was unable to use the pain scale?

A. I don't know what I meant with that.

Q. Did you actually perform a physical examination of [redacted] from a nursing standpoint?

A. I performed a nursing assessment.

Q. Okay. Can you tell me generally what you did from an exam point of view in your nursing assessment?

A. The best I can remember and what I documented, I listened to his lungs, listened to his abdomen, touched his abdomen. Just an overall general appearance.

Q. What were you looking for when you looked in his ears?

A. I don't know that I did. That -- sometimes a physician -- if I'm in the room and the physician looks in his ears and he says they are clear, or I

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will ask him what they look like or whoever the practitioner is.

Q. Well, here we have a notation at 7:55 at the bottom says, "EENT: Tympanic membrane clear on right ear and left ear. Ear canal on right and left ear, oral mucosa is moist."

Now, the question I have now is, is that as a result of your personal exam of [redacted] or are you recording what the doctor is telling you?

A. The oral mucosa would be -- I could tell you without a doubt that that's mine.

Q. Okay.

A. Now, how I get to the oral mucosa, since it's computerized, I don't know if you have to go through these, you know, click the buttons or what.

Q. Okay. Here's all I'm trying to find out at this point is: What is written after the letters EENT about the tympanic membranes being clear on the right and left and the ear canal being clear on right and left, is that something that is written as a result of an exam that you did?

A. It could have been. I mean, I...

Q. Well, had anybody else seen -- had Dr. Haynes seen the patient by then?

A. I don't recall what time he went in the room

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Q. Okay. Better question is: What information do you get from the pulse ox?
A. Heart rate and pulse oxygenation.
Q. Okay. Does pulse ox display also respiratory rate?
A. It can. Well, I back up. No, sir, it wouldn't.
Q. Okay. So the pulse oximeter would show oxygen saturation level and the heart rate?
A. Yes, sir.
Q. Okay. But the pulse oximeter would not display his blood pressure, correct?
A. No, sir.
Q. Not correct or it wouldn't do it?
A. It wouldn't. It wouldn't show.
Q. In order to get the blood pressure, you would have to have some sort of automated blood pressure cuff attached to the patient, correct?
A. Or it could be done manually.
Q. Okay. And if there were no automated blood pressure cuffs attached, then it wouldn't be monitoring the blood pressure continually, correct?
A. If it were not attached, no, sir, it wouldn't monitor.
Q. Okay. Can you tell me from reference to the

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record or a reference to your memory what the patient's vital signs were on discharge for [redacted] Guzman on February 12, '06?
A. I can't tell you specifically, no, sir, other than what I documented his heart rate.
Q. Okay. Can you tell me generally what his --
A. I couldn't tell you generally other than the heart rate.
Q. Okay. Was the time that you documented the heart rate at 9:58?
A. Yes, sir. According to the document, yes, sir.
Q. Okay. Other than the notation at 9:58 that says, "No adverse reaction. Heart rate is decreased to 105 dash 110," is there any indication in this chart that his vital signs were ever taken after that before he was discharged?
A. Not documented, no, sir.
MS. BRYAN: Form.
Q. (By Mr. Pfeifer) Okay. And do you have any information from any source at all about what his vital signs were at the time of discharge?
A. I don't have anything recorded, no, sir.
Q. Okay. Are you the person who drew the blood

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for [redacted]
A. I believe I was, yes, sir.
Q. There is a notation here under procedures at about 8:40, "Lab drawn, sent. First IV started peripheral. IV 20-gauge catheter in left antecubital area." Is that correct?
A. Yes, sir.
Q. In the Emergency Department how did you go about making sure that the blood tests that the doctor ordered -- that the doctor had ordered were actually administered?
MS. BRYAN: Form.
A. I'm not sure I understand the question.
Q. (By Mr. Pfeifer) Okay. There is paperwork in the chart where Dr. Haynes has circled "CBC." Do you see that?
A. Which page are you referring to?
Q. I'm looking at page MHSE-11 down at the bottom.
A. At the bottom of the page, sir?
Q. The bottom is the page number.
A. Oh.
Q. The order is up at the top.
A. Yes, sir, I see it.
Q. Okay. Do you see where the letters "CBC"

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are and there appears to be a handwritten "X" mark next to that?
A. Yes, sir.
Q. All right. Did you ever see this order sheet the day that [redacted] was at the emergency room?
A. I'm sure I saw it at some time.
Q. Okay. After the doctor saw [redacted] in his initial exam, did he come out and give you instructions about what he wanted done with regard to [redacted]
A. I can't remember how that happened, if I took the information off of this or if he told me.
Q. Okay. Did you understand back at the time that you were to draw blood for a CBC as reflected on this order sheet?
A. Again, I'm not sure I understand what the question is.
Q. Let me go at it this way: How did you get the information that you were supposed to go draw the blood?
A. Like I said, I don't know how I got it off of there, whether I got it off of the paper or whether he told me, or possibly both.
Q. Okay. Did you understand that you were drawing blood for a CBC which included the white cell

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Q. Okay. So we know somehow you knew that an order had been entered for a CBC and a BMP to go to the laboratory, correct?
A. Yes, sir.
Q. Because you went and drew the blood in two different, separate containers, marked the blood, labeled the blood, and sent it to the lab, correct?
A. Yes, sir.
Q. Okay. Now, that gets the blood to the lab. Now, my question has to do with following up on those results. Okay? And what I'm trying to find out is whether you had ever been taught at the Emergency Department at Memorial Southeast that it was part of your job to go back and verify whether labs that had been ordered for which blood was drawn were actually completed before the patient is discharged. You understand that?
A. Yes, sir.
Q. So what's your answer?
A. It was not my job to verify that anything was completed.
Q. Was it your job to make sure that vital signs were repeated and recorded in the chart prior to patient discharge?
A. Can I have the question again, please.

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Q. Was it your job as the emergency room nurse taking care of [redacted] Guzman to make sure that his vital signs were taken and recorded in the chart before discharge?
A. If there was a need to put them, if there was something specific that I needed to put in the chart for that.
Q. Okay. Was it left to your discretion to decide whether or not vital signs needed to be repeated for [redacted] Guzman on the day he was in the ER?
MS. BRYAN: Form.
A. I don't know what their policy is.
Q. (By Mr. Pfeifer) So as you sit here today, you don't know what the policy at Memorial ER is with regard to repeating vital signs on patients before discharge?
MS. BRYAN: Form.
A. No, sir, I don't know a specific policy.
Q. (By Mr. Pfeifer) Okay. And did you know of any policies in February of '06?
MS. BRYAN: Form.
A. No, sir, I -- I -- I don't -- no.
VIDEO TECHNICIAN: Need to go off the record and change the tape. It is 11:20.

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(Recess taken.)
VIDEO TECHNICIAN: We're back on the record. It's 11:30.
Q. (By Mr. Pfeifer) All right. We know that -- if you go back to page 13 down at the bottom, at 7:55 you did an initial assessment of [redacted] correct?
A. Yes, sir.
Q. And as a result of that assessment, did you consider at the time that he was stable?
A. Yes, sir.
Q. Can you tell me by looking at your resume here who some of these people are? There is listed Charlotte Ware, RN.
A. A nurse that I have worked with.
Q. At Memorial or --
A. Yes, sir.
Q. Okay. Who is Arthur Schaffer?
A. Actually, that's an ex father-in-law.
Q. Okay. Michael Shaw?
A. Father-in-law now.
Q. Okay. So he is your wife's father?
A. Yes, sir.
Q. Okay. Dr. Nadir?
A. Ali.

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Q. Dr. Ali, I'm sorry. How do you know Dr. Ali?
A. From Clear Lake Medical Center.
Q. Okay. Did you work for him?
A. With him, yes, sir.
Q. In an emergency department?
A. No, sir, in a cardiac cath lab.
Q. Okay. You have identified on your resume that you were the valedictorian of the associate class in nursing at McLennan County or McLennan Community College?
A. As such, yes, sir.
Q. That mean you were number one?
A. Number one ranking, yes, sir.
Q. In your nursing class?
A. Yes, sir.
Q. In 1996?
A. Yes, sir.
Q. And how many in that class?
A. I can't recall exactly. It changed every semester.
Q. Okay. Several hundred?
A. No, sir. It wasn't several.
Q. Do you know whether they still have a McLennan Community College nursing program?

Plaintiffs' Response to Memorial Hermann Motion for Summary Judgment

Exhibit I

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

WENDY GUZMAN, INDIVIDUALLY AND AS NEXT FRIEND OF [redacted] GUZMAN, A MINOR	:	
V.	:	CIVIL ACTION NO. 07-3973
MEMORIAL HERMANN HOSPITAL SYSTEM, D/B/A MEMORIAL HERMANN SOUTHEAST HOSPITAL	:	

* * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF
TOM FLANAGAN
AND AS MEMORIAL HERMANN HOSPITAL SYSTEM DESIGNEE
January 12, 2009

* * * * * * * * * * * * * *

ORAL AND VIDEOTAPED DEPOSITION OF TOM FLANAGAN AND AS MEMORIAL HERMANN HOSPITAL SYSTEM DESIGNEE, produced as a witness at the instance of the Plaintiff, and duly sworn, was taken in the above-styled and numbered cause on the 12th day of January, 2009, from 1:17 p.m. to 4:25 p.m., before Gretchen C. Dowda, CSR in and for the State of Texas, reported by machine shorthand, at the law offices of Smyser, Kaplan & Veselka, L.L.P., 700 Louisiana St., Suite 2300, Houston, Texas 77002, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

is that?
A. This is a policy. Exhibit No. 7 is a policy regarding admission of patients to the emergency center.
Q. Okay. When you say admission of patients to the emergency center, exactly what are you describing there?
A. When patients -- when a person presents to the emergency department and requests to be seen.
Q. Okay. Was that policy and procedure also in effect back in 2006 in February?
A. According to the dates here, yes.
Q. Okay. I'm going to hand you Exhibit 8. What's that?
A. This is the triage policy.
Q. And it was -- was it in force and effect at Memorial Southeast back in February of 2006?
A. According to the dates on here, yes.
Q. Okay. And Exhibit 9 is the document you referred to just a while ago as assessment or reassessment. Was that a policy and procedure that was in force and effect at Memorial Southeast back in February of '06?
A. According to these dates, yes.
Q. Okay.
MS. BRYAN: And just for clarification,

you said Southeast. Is that one Southeast?
A. This one is Memorial Hermann Healthcare Systems. This is Memorial Hermann Healthcare Systems.
MS. BRYAN: Do you want to distinguish between the corporate policies and the Southeast policies, Phil, or --
A. That's Southeast and that's Southeast.
Q. (By Mr. Pfeifer) Okay. All right. Let me ask you this. With regard to a corporate policy would that policy be in force and effect for all the hospitals in the Memorial System, including Memorial Southeast?
A. That is correct.
Q. Okay. On the policies, if it says MHHS at the top, does that indicate that it is Memorial Hermann Hospital Southeast or -- I guess that really doesn't refer to it, does it?
A. No.
Q. Okay.
A. But you can look for it -- let me just show it to you so you'll see the difference. It's Memorial Hermann Healthcare System, Memorial Hermann Healthcare System.
Q. All right.
A. They just didn't put the "C" in. Down here the second title --

Q. Yes.
A. -- tells you this is a Southeast based policy. This one -- these two do not have that on there.
Q. Okay.
A. So it's corporate.
Q. Okay. Who maintains the policies and procedure manual for corporate policies about the emergency department?
A. Today or then?
Q. Back then.
A. It would have been me.
Q. Okay. And who does today?
A. I can't answer that.
Q. Okay.
A. Sorry.
Q. Back in '06 who was it that maintained the policy and procedure manual for the emergency department at Memorial Southeast?
A. As I recall, the director at that time was Christine Wiese.
Q. Do you know if she's still there in that job?
A. No, she's not.
Q. Do you know where she is now?
A. I couldn't tell you.

Q. Is she still with Memorial or did she leave --
A. No.
Q. -- Memorial?
A. She left after -- she left the city. That's all I do know.
Q. All right. At any point in time did corporate management such as yourself review the Memorial Southeast policies and compare them with the corporate policies of the Memorial System to determine whether they were consistent?
A. Rephrase that for me.
Q. Was there any point in time where you or anybody under your supervision or direction was asked to go compare the emergency room policies and procedures of Memorial Southeast with the corporate system-wide policies and procedures to see if they were congruent or whether they were in conflict?
A. No.
Q. Okay. To your knowledge have we identified in these documents that we have marked here 6, 7, 8, 9, I guess 4, as being all of the policies and procedures that would relate to emergency care as relates to what nurses do in the emergency department at Memorial Southeast?
MS. BRYAN: The only thing I'm going to

Q. Okay.
MS. BRYAN: And when we produced these documents in response to whatever document request they came from, we produced all the ones that we thought were responsive to this case.
Q. Okay. All right. Very good. But what you're telling me and what I think you testified to before, there may be predecessor policies. If we were to ask you to go back and click on febrile illness, for example, you would be able to click on it, look at the policy, and see whether it was a new policy as of November 20 of '07 or whether there was some previous policy. Would that be accurate?
A. That is correct --
Q. Okay.
A. -- as I recall.
Q. All right. Then there is a policy EMS-00032 that says Treatment of Emergency Patients by Emergency Physicians. Are you familiar with that policy?
A. Not off the top of my head, no.
Q. Okay. Can you tell me just generally what it discussed without --
A. I couldn't unfortunately, I'm sorry.
Q. Okay.
A. I would have to literally go and look at it.

Q. Okay. 00027 talks about Transportation of Emergency Center Patients to Interdepartmental Areas. Does that mean areas within the Memorial Southeast Hospital or does it deal with transfers between hospitals?
A. That as I recall, best of my recollection, it's related to departments within Memorial Hermann Southeast.
Q. In other words, if you're taking the patient out of the emergency department to go to radiology for an MRI or CT scan and then bringing them back to the ER, would these policies relate to that kind of thing?
A. That's correct.
Q. Okay. What is the EMS-00029 about evidence preservation? What does that have to do with?
A. I would have to go back and look at that.
Q. Okay.
A. I couldn't just tell you off the top of my head.
MS. BRYAN: From my experience, things like rape kits or any sort of police chain of custody issue but...
MR. PFEIFER: Okay.
A. I would think that may be what it is. I don't -- but I can't...

Q. (By Mr. Pfeifer) All right. Let's go back to our list of things I asked you to bring.
A. Okay.
Q. Have we covered everything then on 3 of which you are aware?
A. As I recall, that I'm aware of, yeah, I believe so.
Q. Okay. Number 4 talks about policies and procedures concerning monitoring of vital signs as related to the emergency department. Would that be the assessment, reassessment policy that you described?
A. May I look at that policy?
MS. BRYAN: I think it's in this stack.
A. I may have it. Okay. Let me look at that. If you'll give me just a moment.
And repeat your question, please.
Q. (By Mr. Pfeifer) Is the assessment policy that you have in your hand, Exhibit 9, the only policy and procedure concerning monitoring of vital signs as related to the emergency department at Memorial Southeast?
A. That is correct. It is addressed in this policy.
Q. Okay.
A. Exhibit 9.

Q. Okay. And it looks like you're the one who approved that policy?
A. It does look that way, doesn't it?
Q. Okay. All right. Now, number 5.
A. Uh-huh.
Q. Any policies and procedures, any clinical pathways for pediatric patients in the emergency department at Memorial Hermann Southeast for the following types of patients. And then we have patients presenting with complaints or symptom of fever.
Were there any clinical pathways for those kinds of patients?
A. I have tried to recall and I do not recall that we had any clinical pathways at that time in the emergency department there.
Q. Okay. Would that be -- well, let me just cover b and c then. Were there any clinical pathways about patients presenting with complaints or symptoms of nausea or vomiting to your knowledge?
A. Not that I can recall. I'm sorry.
Q. Okay. And finally, patients presenting with complaints of cough?
A. Same thing, not that I can recall.
Q. Okay. Do you know whether or not there were clinical pathways of any kind for any condition for

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patients presenting to the ERs at Memorial Hermann Southeast back in February of '06?
A. At Southeast I can't recall that we had any in place at that time.
Q. Okay. Then, let me back up for just a second and ask this general question: What do you understand to be a clinical pathway for -- in terms of the emergency department?
A. My understanding is a clinical pathway is a standardized form, format and standardized protocol set forth by physicians so that you can treat patients if they fall under that protocol --
Q. Okay.
A. -- and not have to wait for a physician order.
Q. Now, back in February of '06 did Memorial have clinical pathways for any kind of condition within the emergency department at any of the hospitals to your knowledge?
This is broad as it can get and I'll try to narrow it down. For example, were there clinical pathways for things like heart attack or stroke or --
A. In '06. I know that our Level One Trauma Center, our downtown campus, has some pathways. How long they have been in place, I can't -- I can't -- I

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can't -- I don't know.
But the Level One Trauma Center was the one campus where you would -- that I recall where we dealt with clinical pathways, not the community hospitals.
Q. In other words, the Memorial Hermann Hospital ER was the one where there were clinical pathways but not at the community outlying hospitals?
A. Memorial Hermann Hospital, what we know today as Memorial Hermann Hospital TMC. Texas Medical Center.
Q. TMC, okay. The one where Life Flight arrives?
A. Correct.
Q. But to your knowledge back in '06 there were no clinical pathways that the hospital had adopted?
A. Not at the community hospitals that I recall.
Q. Okay.
A. Not that I...
MR. BRENNIG: And just so we're clear, when you say "community hospital," does that include Memorial Hermann Southeast?
THE WITNESS: Yes.
MR. BRENNIG: I just wanted to be clear.
MS. BRYAN: All the Memorial --
MR. BRENNIG: I thought so.
A. When I'm saying the community hospitals, I'm

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using all of them except the Texas Medical Center campus, the Level One Trauma Center.
MR. BRENNIG: Perfect.
Q. (By Mr. Pfeifer) All right. I want to skip down now to number eight. You have brought the medical staff bylaws with you here, correct?
A. Yes.
Q. All right. There was something that was tabbed here before I started reading it with the indication that this was the only thing that may relate to EMTALA. And it has to do I think with page 129 of the bylaws about mid-level providers may perform medical screening exams on non-urgent patients in the emergency room under the direct supervision and delegation of the emergency room physician.
How in your mind does that relate to EMTALA?
A. Could I see that?
Q. Sure. Of course.
A. Repeat your question again.
Q. How does that quoted portion of the medical staff bylaws in your mind relate to EMTALA?
A. In my understanding it's that EMTALA clearly delineates that every individual has the right when they walk into an emergency department for an evaluation to

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determine if an emergency medical condition exists.
And part of getting to the point of emergency medical condition existing is performing the medical screen evaluation. And so, it can only be performed by certain personnel on the staff of the hospital. And so, the bylaws reflect -- the medical staff bylaws reflect what we, that campus, would allow to be performed at a mid-level provider or under the direct supervision of an M.D., that the mid-level provider could perform the medical screen, which it goes back to Exhibit No. 5, my lovely drawing of this bucket of folks.
The medical screen is performed by the qualified medical provider, which could be either the, according to your bylaws, the mid-level provider or the medical director.
Q. Now, the -- is the medical director a physician?
A. The medical director of the emergency department?
Q. Yes.
A. Yes.
Q. Okay. With regard to mid-level providers are you talking about physician's assistants or are you talking about nurse practitioners or are you talking

Q. Okay.
A. Date. And I think discharge disposition.
Q. Okay. And with regard to discharge disposition, are you talking about whether they were admitted to the hospital, not admitted, or thirdly, transferred to another facility?
A. Correct.
Q. Okay. Would there be any other options besides those three?
A. Not that I can recall at this time.
Q. Okay. Anything else you can think of which would be data query fields for MEDHOST system?
A. I think that from what I can recall that pretty much covers it.
MR. PFEIFER: Okay. Why don't we stop right now and see if we've got the fax in.
MS. BRYAN: We didn't get the right information, so we'll go call. We'll take a quick break and go call.
VIDEO TECHNICIAN: We're off the record at 3:00.
(Recess taken.)
VIDEO TECHNICIAN: We're back on the record. It's 3:08.
Q. (By Mr. Pfeifer) Okay. Let's look again

at -- I want to go back to this exhibit that you brought with you here today. I think it's Exhibit 4.
A. Uh-huh.
Q. Okay?
A. Yes, sir.
Q. And I'm not sure we have all the pages of it. Let me just ask you about it. Would you look at the bottom of the page that is Bates stamped 140?
A. Yes, sir.
Q. And do you see under 3.3.1 it says, patients -- it talks about presenting with minor complaint on non-emergency list. (See 3.6.) Correct?
A. Yes, sir.
Q. Well, I don't see a 3.6. And also the list on page 142, the last page, seems to start with "I" and does it look to you like it's in alphabetical order?
A. It sure does.
Q. Where are A through I?
A. Well, I need to go back and take a look.
Q. Okay.
A. And that was -- this is -- I'm the one that devised this process, so I can speak to this. This is the non-emergency list, part of it. But you are correct, we're missing two pages.
MS. BRYAN: My fault. Two pages.

THE WITNESS: We're missing page 3.5 behind that. And then -- well, may only be one page. May only be one page. Actually when we -- what did you say?
MS. BRYAN: I said, it's not my day.
THE WITNESS: No. And that's my -- that was my issue because I --
MS. BRYAN: Okay. We'll investigate the missing pages. And as soon as I find them, I will give them to you. I can do that on a different break. Can you cover -- can you go ahead and cover things?
MR. PFEIFER: I'll try to cover some other stuff while we're waiting on the page that you have requested to be faxed to you. Maybe we can --
THE WITNESS: Can we take a break and I'll call Mike?
MS. BRYAN: You want to try to look for it?
THE WITNESS: Yeah. I can get it for you.
MR. PFEIFER: Go back off the record.
VIDEO TECHNICIAN: Off the record at 3:11.
(Recess taken.)
VIDEO TECHNICIAN: Back on the record at

3:18.
Q. (By Mr. Pfeifer) Okay, Mr. Flanagan, we have before us a document which is Exhibit 11. First of all, can you tell me what that document purports to show?
A. Yes. What it's showing is, it's a change request detail from our information systems.
Q. So that's talking about the computer information system?
A. It is. Correct, it is talking about computer. Any changes we are making in the computer system during the course of business. And a change request has to go in to information systems. And then it shows here the date, the time, the solution segment, the description.
And so what it shows is on the date of February 12, 2006 at midnight, the system came down until February 12, 2006 at 2:00 a.m. in the morning. So for two hours the system came down for patient management to achieve older accounts from Healthquest system. It's a typical, every night at midnight the system goes down because it starts dumping older accounts into another system. So it takes -- it usually takes about anywhere from an hour and a half to two hours to dump. So when it's dumping, the system is down. So it's showing on that day that was the only

reason why the system was down.
If you take a look right underneath here, it's no emergency customer interruptions. So it didn't crash for any other reason or anything.
Q. All right. So let's try to put this in simple terms. Have we asked you to get information from the business records of the Memorial System about whether or not the hospital information system was functioning on February 12th of '06 during the period of time from 7 in the morning until 11 in the morning, during that time frame?
A. Yes.
Q. Okay. And have you provided to us in this document Exhibit 11 evidence of all of the times at which the computer system is reported to have been down for any reason?
A. That is correct, yes, I have.
Q. And the only period of time when the computer system was down on that day was during the time period between midnight and 2 a m. Is that what this record shows?
A. That is correct.
Q. So from the standpoint of the records of the Memorial Hermann Hospital System, the computer hospital information system was functioning during the period of

time from 7 in the morning to 11 in the morning on February the 12th of '06?
A. That is correct.
Q. Okay. And when we say the hospital information system was functioning, does that include the ability of personnel such as physicians or nurses to be able to review on the computer laboratory data that is sent from the laboratory system on to the hospital information system?
A. Yes.
(Flanagan Exhibit No. 10 marked.)
Q. Okay. I'm going to hand you now what's been marked as Exhibit 10. And is Exhibit 10 the same thing as Exhibit 4 except it has all the pages?
A. It is the same as Exhibit 4. It is all inclusive.
Q. Okay.
MS. BRYAN: Do you have a copy?
THE WITNESS: Yes, I do. Here.
Q. (By Mr. Pfeifer) It's my understanding that Exhibit 10, then, would include the information about the medical screening exam to be performed by a qualified non-physician medical personnel when they are doing the MSE on patients that are triaged and determined to be qualified to have a non-medical person

perform the medical screening exam. Is that correct?
A. You need to repeat that.
Q. Okay.
A. Sorry.
Q. You've drawn a diagram here of Exhibit 5?
A. Correct.
Q. And in your diagram you have I guess what you call three buckets of patients. And I guess what I'm trying to figure out is: Is Exhibit 10 applicable to one or more of those buckets of patients that you have drawn?
A. It is applicable to the three buckets, correct.
Q. Okay. This particular procedure in 3.0 provides information about what the MSE consists of, correct?
A. Correct.
Q. Now, the question I have is this: Does this procedure that is described here for the MSE reflect what the MSE must consist of if it is performed by a physician?
MR. BRENNIG: Objection. Overly broad, vague.
MS. BRYAN: Same objection.
MR. BRENNIG: And calls for speculation.

A. Repeat that. I'm sorry.
Q. (By Mr. Pfeifer) I'm trying to determine whether or not the procedure for the MSE that is set forth in 3.1 applies to medical screening examinations that are performed by physicians.
MR. BRENNIG: Objection. Overly broad, vague and calls for speculation.
A. I really can't --
MS. BRYAN: Objection, form.
A. I can't answer that because I am not a physician.
Q. (By Mr. Pfeifer) Let's look at the 3.6 list. This has a non-urgent chief complaint. Okay. What is your understanding of what that means, non-urgent chief complaint?
A. Exactly what that states. Their chief complaint is not -- is non-urgent, meaning non-urgent.
Q. Okay. Under cough it says mild without hemoptysis or respiratory impairment. What does the word "hemoptysis" mean?
A. Blood in the sputum.
Q. And what would constitute respiratory impairment?
A. That would be the individual assessment, but impairment meaning that they -- their resp -- they can't

breathe due to impaired for some reason unknown.
Q. For it to be non-urgent for nausea or vomiting, it has to be resolved for greater than 12 hours, correct?
A. Correct.
Q. And have normal vital signs, correct?
A. Correct.
Q. Is there anything in this non-urgent list that relates to complaints of abdominal pain?
A. Number one, two, three, four, five -- number seven on page 19. The last non-urgent chief complaint dysuria, female - mild, not pregnant, no abdominal pain. And --
Q. I guess a better question is: Is there anything about abdominal pain relating to a male?
A. Not that I can see.
Q. Okay. Let's go back to page 17 of this exhibit under 3.1. Under 3.1.8 it says General Appearance. Does the patient look well or ill? Okay?
To me that's very general and nonspecific. Do emergency room people have a way to classify people according to whether they seem well or ill?
A. No.
Q. Can you tell me what criteria one might use to

determine whether someone appears well or ill?
A. My understanding of this is that number eight is giving -- general appearance is one of the indicators when you look at assessing a patient. When I look at your general appearance, that would be your general appearance, okay?
What they're trying to put in here is, in other words, do they look sick, do they not look sick? Do they look like they are in distress? Do they look like they might be anxious? What's their color looking like? All of those things that are done through observation and through experience.
Q. So I take it that whether they look well or ill is important in the experience of someone who is doing a medical screening exam to determine whether they have an emergency medical condition?
MS. BRYAN: Objection, form.
MR. BRENNIG: Objection. Over broad, vague?
A. Can you rephrase that for me?
Q. (By Mr. Pfeifer) I take it, then, that the description of someone looking well or ill is an important factor to consider in whether a person might have an emergency medical condition?
MS. BRYAN: Objection, form. Over broad.

MR. BRENNIG: Objection. Over broad, vague.
MS. BRYAN: Speculation.
A. My answer is not necessarily, no.
Q. (By Mr. Pfeifer) What constitutes the vital signs that should be taken in the emergency department with regard to the assessment of a patient?
A. From a nursing perspective?
Q. Yes.
A. The blood pressure, heart rate, respiratory, temperature. And typically those are the baseline vital signs you would take.
Q. Okay. Would you also consider pulse oxymetry?
A. Not as a vital sign, no.
Q. Okay. Are you able to tell me whether or not at Memorial Southeast in February of 2006 there were any specific requirements on physicians on what laboratory tests should be done to evaluate pediatric patients whose primary complaint was cough, nausea, vomiting and fever?
A. Can you repeat that question? You want to know if there was what?
Q. What I want to know is whether there were any written policies or procedures of Memorial that related to what should be done to perform the medical screening

exam for a pediatric patient who presents with chief complaint of vomiting, number one, cough, fever?
A. Absolutely not.
Q. For that kind of patient, if they proceed through triage and the triage suggests that they be seen by the, I think you said, intermediate level provider?
A. Mid-level.
Q. Mid-level provider. Would that exam by the mid-level provider --
MS. BRYAN: Let me -- I can either object at the end of question or not. But if there is a fever, they're not going to a mid-level provider.
Q. All right.
MS. BRYAN: I'm sorry. I'll let you ask your --
Q. (By Mr. Pfeifer) Well, is that right?
A. That is correct. I was waiting until you got to the end so...
Q. Okay. If they have a fever that is measured, right, on triage?
A. Uh-huh.
Q. Is that what you mean?
A. Okay. Triage doesn't determine or suggest who is going to see the patient. Let me clarify that real clear.

Q. Okay.
A. Triage doesn't make that decision. It's the nurse and the mid-level provider who is working on the direct supervision and through delegation protocols under the physician, they make the decision of who is going to see what patient based upon acuity, volume, all that's going on in the department. And obviously, experience and expertise.
Triage makes no decision as to who will evaluate. Their job at triage from nursing is to assess and to sort patients. That's it.
Q. Okay. Well, maybe I didn't understand. And let me back up, then.
A. Okay.
Q. We know in this particular case that the triage nurse was April Ganz --
A. Uh-huh.
Q. -- involving [redacted] Guzman. Okay? And April Ganz did some sorting of some sort and placed him in a level, a certain level based on the triage.
Does the level of the triage have anything to do at all with whether they are seen by a mid-level provider or by a physician for the performance of the medical screening exam?
A. Too broad.

Q. Okay.
A. You have thrown too many things in there. I can't answer that.
Q. All right. Who makes the decision as to which of the three buckets the patient is put into on your Exhibit 5?
A. The triage nurse.
Q. Okay. Do those three buckets that you have described have any relationship to the level, the emergency room level that is assigned to the patient by the triage nurse?
A. Yes, it is part of it.
Q. Okay. So which levels go in the bucket that are seen by the intermediate provider?
A. On the system that we use, level one through five -- I've got to look at my level one through five actually.
MS. BRYAN: The triage policy?
THE WITNESS: Yeah, I think it's in there. It should be in here, I thought.
A. Okay. It would be the least acute. Let me put it to you that way. It's not just one level. It could be the last two. Whether it's four and five or one and two -- I can't remember which direction it goes is what I'm trying to tell you.

Uh-huh. Right here.
Q. Okay.
A. So look at Exhibit No. 8 --
Q. All right.
A. -- under the triage policy. So typically level four and level five. These two levels would typically fall into the bucket for the qualified medical person to do the medical screening.
Q. Okay. Now, when QMP, you've written qualified medical person, we have also used the term "intermediate medical provider," or QM --
A. We never used intermediate medical provider. Let me clarify that.
Q. All right.
A. I have used mid-level provider.
Q. Mid-level provider?
A. That is the professional title for PAs and nurse practitioners, --
Q. Okay.
A. -- mid-level provider.
MS. BRYAN: And we also all need to be careful because QMP includes those mid level --
A. And physician. That's what I was getting ready to tell you.
Q. (By Mr. Pfeifer) All right. That's what I

want to get.
A. Right.
Q. Okay. So QMP is mid-level plus physicians?
A. Correct.
Q. Obviously, physicians can see any of them?
A. Absolutely.
Q. Okay. But also for the -- the group that can be seen by a mid-level provider --
A. Uh-huh.
Q. -- that is the acuity levels you have indicated here on Exhibit 8?
A. Typically that is correct.
Q. Okay.
A. Level four, non-urgent level five routine can be seen by a mid-level provider. The --
Q. Okay.
A. -- medical screen evaluation and examination is done by both, according to our bylaws, the emergency room physician and/or the mid-level providers. So they both provide screens to all patients.
Q. Okay.
A. And can.
Q. All right. But what you're saying is that typically one and two levels will be seen by the mid-level provider?

A. Four and five.
Q. I'm sorry. Four and five are seen by the mid-level providers?
A. Can be.
Q. Can be.
A. Uh-huh.
Q. Okay. Can a mid-level provider see a level one?
A. To screen them out?
Q. Yes.
A. Typically, that does not happen, no.
Q. Okay.
A. Huh-uh. If they're critical, then there is no even need to get the mid-level provider if they are critical.
Q. I guess what I'm trying to figure out is this: On the Exhibit 10 that you have here that we have identified --
A. Uh-huh.
Q. -- does that identification of what constitutes a medical screening exam apply to physicians or mid-level providers or both?
MR. BRENNIG: Objection. Over broad, vague, calls for speculation.
A. My answer to that is no.

Q. (By Mr. Pfeifer) Then to whom does it apply?
A. This -- the title of this policy is not a medical screening exam. Okay? This is medical screening criteria to timely identify patients presenting with an emergency medical condition.
If you read in the very, the very -- 1.1.1, I refer you to page 16, "These criteria are to be used for screening purposes as a guideline" -- this is not -- these are criteria when performing a medical screen exam. This is not the end all be all of the medical screening exam.
Q. They are criteria?
MS. BRYAN: To --
A. To -- to -- to be able to identify patients presenting without an emergency medical condition. So it's --
Q. Okay. In other words, when you say to identify patients who are presenting without an emergency medical condition, you're saying to rule out those patients who do not have an emergency medical condition?
MS. BRYAN: I'm just going to object because I have -- you had a double negative so I'm trying to figure out what the question is.
A. These are criteria that we built, that I built

with the physicians, okay, so that we had some guidelines and criteria for mid-level providers when trying to do medical screening. It is not the medical screen.
I'm hearing two things in your statement to me. My ears are hearing you ask me if these criteria here are what we use or these steps here is what we use to do a medical screen. It is not the medical screen end all and be all in itself.
These are criteria to help them get to the point of making decisions of, do we need to do more, do we need to add more to determine if an emergency medical condition exists or not. So I -- the one thing I don't want is people walking out of this room thinking that this is our medical screen. It is not.
Q. Okay.
A. Am I making sense?
Q. Well, we'll see.
A. Okay.
Q. Would you agree with me that a medical screening examination for a particular patient must be one that helps identify whether or not the patient has an emergency medical condition?
MS. BRYAN: Objection, form.
A. Repeat that one more time. I'm sorry. I am

really getting tired. Repeat that one more time.
Q. (By Mr. Pfeifer) Would you agree with me that a medical screening exam is a process by which it is determined whether a patient has an emergency medical condition?
MS. BRYAN: Form.
A. Yes.
Q. (By Mr. Pfeifer) Would you agree with me that there can be several steps to that process?
A. Yes.
Q. Would you agree with me that that process may be different, depending on different complaints of patients?
A. Yes.
MS. BRYAN: Form.
Q. (By Mr. Pfeifer) Okay. Does Memorial or did Memorial, back in 2006 in February when [redacted] Guzman was there, have written requirements for the minimum level of a medical screening examination for a patient who presented with a history of nausea and vomiting, pediatric, cough, and a subjective complaint by the mother of fever?
A. Not that I'm aware of.
Q. Okay. To your knowledge were there any written policies or procedures of Memorial that at that

time identified the minimum medical screening exam for a patient who presented with a complaint of vomiting?
A. Not that I can recall.
Q. Okay. Same question with regard to a patient, a pediatric patient who presents with a complaint of cough.
A. Not that I recall.
Q. Okay. Same question for a patient that presents with complaints of subjective fever.
A. Not that I recall.
Q. Okay. So how is it determined what level of medical screening exam will be given to each particular patient at Memorial back in February of '06?
A. I'm going to try to remain very calm. As you can tell, I'm getting very anxious.
MS. BRYAN: If you're getting anxious, we need to take a break.
A. Well, hold on. What I'm hearing you ask me, what I'm hearing you say -- I'm trying to educate people. The medical screen -- I'm hearing you look to me like the medical screen we have a posit that says this will be done for vomiting for medical screening, this will be done for this.
Medical screening is not a -- a recipe cookbook in the emergency department at all. Medical

screen is based upon multiple, multiple factors, all related to the patient in front of you.
And based upon your education, your experience, your expertise, there is many more -- that's how these decisions are made. It's not just every patient that comes in with a cough we will do this, this, this and this and this, and if all that's negative, then they can go home. No.
It's all -- it's based upon experience, education, training, age, maturity. I mean, all those things come into play, just -- just very much in your profession. The young lawyer that comes out of law school is going to change the world. He doesn't have a recipe and a cookbook. How did you get to become so good in your arena, because your years of experience and expertise and all of those things.
And the reason I'm -- I'm getting frustrated -- and I apologize, it's not personal -- is we are -- we do 350,000 medical screens a year. Okay? We do them. We see 350,000 patients in our ERs. They come in, they sign in, we see them whether they have money or insurance.
MS. BRYAN: I'm going to ask you to finish your answer and we're going to take a break.
A. Okay. The medical screen is done. What I'm

hearing you ask is: Does Hermann or Memorial Hermann have a policy or a process for a patient who comes in with nausea or vomiting, of what the medical screen consists of? No.
It -- part of the medical screening, that's the reason we hire you. And that's how come it can't be done by a nurse is because --
MS. BRYAN: Okay.
A. -- of your experience, expertise, your education, your years as an emergency room physician. Where have you practiced, what you've done. That all is part of determining, you know, through -- just like when you said here, the question, general appearance. Does the patient look well or ill. Do I look like I'm in pain? I'm smiling, I'm not sweating. No. That's general appearance.
MS. BRYAN: Okay. There is no question. Let's take a break.
A. Sorry.
VIDEO TECHNICIAN: Off the record. It is 3:52.
(Recess taken.)
VIDEO TECHNICIAN: We're back on the record. It'S 3:57.
Q. (By Mr. Pfeifer) Are you ready to proceed?

A. I'm ready.
Q. Okay. Have you reviewed any of the medical records concerning [redacted] Guzman?
A. No, I have not.
Q. Okay. How long has it been since you have actually done clinical practice in an emergency department?
A. Actually, it may have been '05 or '06. I may have -- I may have either flown or been in the E.D. for sure.
Q. Okay. Were you doing it at that time just to keep your skills up and --
A. Actually we -- I had taken over one of our other E.R.s as the interim director. And so -- I'm from a liberate that you must model what you want your staff to be doing so we -- by example. So I would go in and take care of patients and take assignments as a director and show them what my expectations were.
Q. Okay. Was it your understanding as an E.D. nurse working in 2006 --
A. Uh-huh.
Q. -- that, if a physician ordered a CBC, that that would include the automated CBC and a differential?
A. I was not aware that it would include a differential. I came from a system where it did not, so

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I'm not -- I mean, I guess some systems they do and some systems they don't.
Q. Okay.
A. So I was not --
Q. All right.
A. -- bluntly aware of it.
Q. As an E.D. nurse, were you familiar with what a differential was used for?
A. From a nursing perspective, I'm fairly comfortable with my understanding.
Q. Okay. What was -- what was your understanding generally speaking of what a differential was used for?
A. Typically as a second -- what would the word be? I look at -- to explain what I'm trying to share is, there is a set, so to speak, of, let's say, lab values that you would get. And based upon what those showed, then you would drill it farther down to a subset of differential. The differential.
So the differential is never a primary set in the E.R.s I worked in. It was always looked at as a second set of indicators but never the primary indicators.
Q. Okay. And a second set of indicators of inflammation or infection?
A. Typically, yeah. Typically.

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Q. You understand that the purpose of my questions before the break were simply to try to identify what was in writing and what was not?
A. Okay.
Q. You understand that?
A. Okay.
Q. Did you feel that I was being rude in the questions that I asked you?
A. No, I didn't think you were being rude. You have to understand I have a lot of passion for what I do. And this whole policy obviously is personal to me because I was the person that redesigned our emergency departments due to the overcrowding. And so the whole genesis of this was not to -- it's not to teach our physicians about medical screening.
Q. Yeah.
A. Okay? It was for our mid-level providers who had never done medical screening, to get them to the understanding of what the expectation was, how they would go about it in a systematic step-wise fashion. Okay?
So when you kept going back to, so the physician, this is the medical screen. It's not the medical screen. And this was never -- this policy was never set forth for the physicians. We don't -- we

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don't dictate to the physicians how to practice medicine. The physicians come with that expertise.
So this was strictly for the mid-level providers, because they had never done this before. And because we're a firm believer in providing medical screenings for all of our patients and we're looking at being able to free up the emergency departments for patients that don't need to be there so we can treat those that are critically ill and injured and so on and so forth, we want to insure that everything is tightly documented and in a nice format so that, when we teach our mid-level providers, they can start following through.
I can't even tell you -- you know, a physician, they may follow this; but this is not -- was never designed for them.
Q. Okay.
A. So you weren't rude. Let me clarify that for the record.
Q. All right. Do you know of anywhere where it is written down what the hospital expects of the physicians in the performance of medical screening exams?
MS. BRYAN: Form.
A. I -- I wouldn't know that, no.

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Q. Okay.
A. Huh-uh.
Q. To your knowledge there is no such written document?
A. No, huh-uh.
Q. How would we know, then, whether or not the patients were being processed in the same manner by different doctors?
MS. BRYAN: Form.
A. I'm not sure that I can answer that. Process?
Q. (By Mr. Pfeifer) In other words, whether they were worked up in a similar manner?
MS. BRYAN: Objection, form.
A. From a process perspective I'm pretty confident all of our patients follow the same process.
Q. (By Mr. Pfeifer) Okay. And what do you mean by "process" in terms of --
A. They come to triage, they are triaged and sorted. They are acuitized. And based upon that, whether they are screened in or they're screened out -- if they're screened in and they're in a room, the nurse comes in and does an assessment, the doctor comes in and does an exam. Based upon the physician orders, those orders are carried out. Based upon the results of those orders, the decision is made whether to admit or

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discharge. And then based on those orders, the nurse follows through and either discharges them out with instructions or admits them up into the house.
Q. Okay.
A. So in process our patients throughout the system follow the exact same process
Q. Okay. My question really didn't have to deal with process. Okay?
A. Okay.
Q. My question deals with this: Would you assume that if a patient with a relatively straightforward set of complaints -- and by that I mean just nausea, vomiting, some cough, Mom says they have a fever -- that doesn't sound to be real complex in terms of those levels of complaints.
Would you expect that that kind of patient would get a similar work-up in terms of the physical exam and the lab tests that are ordered for that patient among different physicians at the hospital?
MR. BRENNIG: Objection.
MS. BRYAN: Form.
MR. BRENNIG: Vague, overly broad, calls for speculation.
A. I don't know that I am qualified to answer

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that actually.
Q. (By Mr. Pfeifer) Okay. All you can tell me is, there is nothing written down at the hospital that would require that kind of patient to be given the same kind of exam, the same kind of laboratory tests physician to physician. Would that be correct?
MS. BRYAN: Form.
A. We don't -- we have no policies or any of -- that would be practicing corporate medicine. Huh-uh.
Q. With regard to Memorial, I know you're a passionate guy about Memorial, and the provision of emergency services at the hospital, you have testified that.
A. Uh-huh.
Q. And I know you feel strongly that they try to provide a high level of quality of care.
A. Uh-huh.
Q. Yes?
A. Yes.
MS. BRYAN: You have to say "yes."
A. I'm sorry.
Q. (By Mr. Pfeifer) And I know that you feel that they provide a good return of service in exchange for the compensation that they charge people?
A. I believe that, yes.

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Q. Okay. If a patient is billed for a particular service, do you think they should receive that service?
MS. BRYAN: Objection, form.
MR. BRENNIG: Objection. Overly broad, vague, calls for speculation. No foundation.
A. Repeat that question. If what?
Q. (By Mr. Pfeifer) If a patient is billed by the hospital for the service, wouldn't you expect that that service would have been performed --
MS. BRYAN: Same objection.
MR. BRENNIG: Objection.
Q. -- on behalf of the patient?
MR. BRENNIG: Overly broad, vague.
A. Yes.
MR. BRENNIG: Calls for speculation.
Q. (By Mr. Pfeifer) Okay. And even though the hospital can perform a service such as an x-ray for a patient --
A. Uh-huh.
Q. -- if that particular service is not reviewed by a physician, it doesn't do any good, does it?
MS. BRYAN: Objection, form.
MR. BRENNIG: Objection. Overly broad, vague, calls for speculation, no foundation.
A. Repeat that.

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Q. (By Mr. Pfeifer) Well, if a patient is billed for an x-ray and nobody reviewed the x-ray, what good does it do the patient?
MS. BRYAN: Objection, form.
MR. BRENNIG: Objection. Vague, overly broad. No foundation, calls for speculation.
A. Good question. I'm not sure.
Q. (By Mr. Pfeifer) Would you agree with me, sir, that the medical screening exam is a process where it may be continuing over a course of several hours in an emergency department as more information is gleaned--
MS. BRYAN: Objection.
Q. (By Mr. Pfeifer) -- about the patient?
MS. BRYAN: Objection, form.
A. I can't answer that because I'm not a physician that can perform that evaluation.
Q. (By Mr. Pfeifer) Well, how about your mid-level providers? Haven't you written policies and procedures for what's required for the mid-level providers in terms of guidelines for the medical screening exam?
MS. BRYAN: Objection, form. Listen to the question; answer the question.
A. I have not -- I have not written those.